		For State Registrar	State of Maryland		artment of H			iene 9. No. 201	14 0850
Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of Death Month March	Day Y	3. Time of Death
/Medio Examir		Mary J. Copper 4a. Facility Name (If not institution, give si Glen Meadows	treet and number)		4b. City, Town, or Glen Arm			4c. County of Balti	Death
Funeral Director		5. Social Security Number 6. Sex 4D8-24-1972	7. Age (In yrs. In	ast birthdey) Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day, Jan. 1,	Year) 9 1921	Birthplace (State or Foreign Country)
Maryland 8-f show	tor	Usual Residence of Decedent 10a. State 10b. County MD Baltimor		, Town or Lo Len Ari					10d. Inside City Limits 1 ☐ Yes 2 🕱 No
vith the	Director	10e. Street and Number			10f. Zip Code		10	og. Citizen of Wha	
eath v	erai	11630 Glen Arm Roa	2. Was Decedent Ever in U.S	S 13 V	21 057 Was Decedent of Hi	spanic Origin? (S	pecify Yes or No-	United	States American Indian,
ours after d ai', or item Examinen	by Funerai	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	'	fYes, specify Cuba 1 □ Yes 2 🕱 No	n, Mexican, Puert Specify:	o Rican, etc.)		white, etc. White
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Important of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ital Medical Examination in Italian and Once.	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give life. I	dent's Usual Occupa kind of work done of DO NOT use retired	turing most of wor	king	16b. Kind of Busir	
d 2 should be filed within 72 hours aft th and Mental Hygiene. It is marked other than "natural", or traumatic event, Ita Medical Examitraumatic	Be	17. Father's Name (First, Middle, Last) Frank Jones		H	omemaker	18. Mother's Nan	ne (First, Middle, M Eppersor	Maiden Sumame)	n Home
should and Me s mark	Ď,	19a. Informant's Name/Relationship (Typ.	oe, Print)	19b. Mailir	ng Address (Street a				ate, Zip Code)
oermit. Pages 1 and 2 Department of Health is mportant: If itam 27 Is any injury or other tra		Carolyn Bryson/da 20a. Method of Disposition 1	20b. Pl	ace of Dispo	10th Str		Date 2	20c. Location - Cit	
ermit. Pag lepartment mportant: I ny injury o		`4 □Donation 5 □Other (Specify) 21. Signature #Funeral Service Licen	Dula	22	alley Mem	Grdn.	luck Tows		al Home, Inc.
40 E # 0		23a. Part1. Entel the disease, or complice shock, or heart failure. List only on	cations that caused the death		050 York er the mode of dying		or respiratory arre		21204 Approximate Interval Between
Pnysician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequ	uence of):	ACUDE	NT			Onset and Death
	Examiner	Six prentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence CORONARY Due to (or as a consequence	Jence of): ASTE	ATION RY MS1	FASE			years
rificate be executed ig physician and as the burial-transit	dicai	L a							
The law requires that the death certific site has been signed by the attending page 2 should be detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	
uires that the de n signed by the a uld be detached f		Part II. Other significant conditions con	=	ulting in the u	nderlying cause give	en in Part I.	23e. Did tob	1/	ute to the cause of death?
sician: The law require certificate has been si irector, page 2 should I	Completed	,					24a. Was ar autops perform 1 Yes 2	v 🖍 pric	re autopsy findings available in to completion of cause of th? Yes 2 \(\text{\subset} \) No
Physician: r this certifica ral director,	Be	25. Was case referred to medical examiner?	ospital:		Othe	n 1/	ath (Check only one		
or Attanding Physician: The law requires the after death. Diractor: After this certificate has been signed in by the funeral director, page 2 should be	tion; To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatient 2☐ 28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c. Injury Work	4 Nursing F	lome 5 Reside 28d. Describe ho		(Specify)
al or Attanding s after death. ii Diractor: After	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, str	reet, factory, office		28f. Location (Str City or Town		or Rural Route Number,
To the Hospital or Attanding Physician: The within 24 hours after death. To the Funeral Diractor: After this certificate his completely filled in by the funeral director, page	edical		sician: To the best of my knower: On the basis of examinat and manner stated.						
Tot Comp	Z	29b. Signature and title of certifier	all	2000	29c. License	0433		9d. Date signed (I	Month, Day, Year) 6 2004
5		30. Name and address of person who co		23a) (Type,		BALT/	MORE	MO 2	4204
St Regist	ate rar	31. Date filed (Month, Day, Year) MAD 1 7 2004	32. Registrar's Signa	ture	1				

		,	1 - For State Registrar	State of Ma		epartmei Ce <i>rtifica</i>			and Me		iene 19. No. 20	04	089	502
		,	1. Decedent's Name (First, Middle, Last)							2. Date of Death Month		Year .	3. Time of	
	Physici /Medio		Catherine	٧.	Cave					March		2004	6:10	Ам
	Examin	er	4a. Fecility Name (If not institution, give s Mariner Health of	<i>treet and number)</i> Glen Burt	nie			Location o Burni			4c. County	Arun	de1	
			5. Social Security Number 6. Sex		(In yrs. last birth		r 1 Year	If Under 2		8. Date of Birth			ece (State o	or Foreign
н	Funeral Director			M 2(X) F	92 Y	Months	Days	Hours	Min.	8. Date of Birth (Month, Pay, Jan 28	1912	Coun	MD MD	
	P.		Usuel Residence of Decedent		10c. City, Town							14	Od. Inside C	its Limite
	anylar ehow	_	10a. State 10b. County Marvland Anne Ar	Iobau	TOC. City, Fown		asad	ona			÷	"	1 ☐ Yes	
	28a-f	ecto	Maryland Anne Ar	unuer			ip Code	CHU		10	Og. Citizen of	What Coun		
	with	ā	7845 Elizabeth Ro	and		101.2		21122			-	USA	, .	
	ns 23	era		2. Was Decedent E	ver in U.S.	13. Was Dec				cify Yes or No- Rican, etc.)	14. Rac	e - Americ		
9	after o	Ē	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give	0			n, Mexican Specify:	i, Puerto F	Rican, etc.)		ck, White, y: Whit		
93	72 hours after death with the Maryland netural', or Items 23a or 28a-f ehow disal Evanifrat must be notified at	db	3 ☑ Widowed 4 ☐ Divorced	Year or Dates:										
21215-0036	nett.	Completed by Funeral Director	15. Decedent's Educ (Specify only highest grade	cation completed)	(ecedent's Us Give kind of w life. DO NOT	ork done	during most	t of workin	g i	16b. Kind of B	usiness/Ind	lustry	
12	iene.	ф	Elementary/Secondary (0-12)	College (1-4or 5-	-)		nema k				Ноп	seho1	d	
	Hygi other	Be C	17. Father's Name (First, Middle, Last)		1	1101	Tema K		r's Name	(First, Middle, N				
lan.	Mental Merked o	To B	William H.	Wharton				Jan	ice	Α.	Szhna	itmar		
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. Item 27 le marked other then "netural", or Items 23a or 28a-1 ehow other traumatic event, I'm Madical Examinar must be notified at		19a. Informant's Name/Relationship (Typ	1						Route Number,			Code)	
	1 and 2 Health em 27 ther tr		Ester Smith	(daughter		22.74.4		th Ro		Pasadena			Chan	
Baltimore,	00		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	1	crematory or	other plac	113	arch	18	20c. Location			
ţ	permit. Pages Department of Important: If it any injury or conce.		* 4 □ Donation 5 □ Other (Specify) 21. Signature of Fune II Service Lightse		Cedar	H111 C6)4 Stalling	Baltimo			
Bal	permit. Pag Department Important: I eny injury o		21. Signature of Furieral Service Literise	/ \.						d, MD 21		iai r	olle, i	r . A .
	7		23a. Part1. Enter the disease, or complishock, or heart failure. List only of	ations that oaksed	the death. Do no								Approximat	te
	Physician		Immediate Cause (Final	/	RAFION	1		mon					Onset and	
7	/Medical		disease or condition resulting in death)		consequence of		COC		104					
	Examiner		Sequentially list conditions,	Ay.	PHAG c nsequence of	(A								
	be is	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				÷ 0 .	(. 10	/ E	EDA	10		
	and I-tran	хаш	that initiated events resulting in death) Last	Due to (or as a	FNT consequence of	A -	1	1101	OFIC	CEI	CE DIC	0 -		
,09	icate be executed physician and s the burial-transit			-VAS	CULA	R	E	VEN	1	3		T.		
68760,	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical							27.00		To provide at	30.5.0115		
Box	eath certific attending pl	M/	IF FEMALE: 23b. Was decedent pregnant 2	3c. If yes, outcome of		3 □Ectopic	oregnancy	,				te of delive	*	. =
	death	sicia	in the past 12 months? 1 \(\sum \text{Yes} \) 2 \(\begin{picture}(\begi	4 Pregnant at		5 ☐ Other (s					Mo	onth	Day	Year
P.O.	res that the de signed by the a be detached f	Phys	9 Unknown		A			an in Dawl		220 Did tob	acco use con	ributa ta th	a cause of o	death?
	signed d be d	by	Part II. Other significant conditions con	1 6 %	t not resulting in	ine undenying	cause giv	en in Farti.	•		s 2 🗆 No	3 ☐ Prob		Unknown
Orc	w requir been si should	etec	- DOTFI DIZIT										osy findings	
Records,	siclan: The law certificate has b irector, page 2 s	Completed								24a, Was ar autops perform	y ned?	prior to cor death?	npletion of c	ause of
a			25. Was case referred to medical					26 Place	of Death	(Check only one	No	1 🗌 Yes	280 No	
Vital	Physiclan: this certific ral director,	To Be	examiner?	lospital:	nt 2 ER/Out	patient 3 [Oth Oth			ne 5 🗆 Reside		ner (Specif	()	
J of	Jing Physiclan: After this certific funeral director,		27. Manner of Death	28a. Date of Injur (Month, Day	y 28b. Ti	me of ury	28c. Injur			8d. Describe ho				
Sio	Attending or death.	atic	1 XNatural 5 Pending 2 Accident investigation			М		Yes 2 🗆 I						
Division	or Att	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju- building, etc	ry - At home, fan . (Specify)	m, street, facto	ry, office		2	8f. Location (Sti City or Town		oer or Rura	i Route Nun	nber,
	pital ours al	Ce	29a. Certifier 12 Certifying Phys	sician: To the best of	f my knowledge	death occurre	d at the tin	ne date an	nd place a	and due to the ca	use(s) and m	annor as si	ated	
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	(Check only 2 Medical Examinations)		examination and									s)
	To the within To the	Me	29b. Signature and title of certifier			2	9c. Licens	e number		25	9d. Date signe	d (Month,	Day, Year)	
			14) har	work	· ca)	177	<u>£</u> 2		3	.15	·04	٠
	X		30. Name and address of person who co				5,0c	T H	~	BALT	MADE	- 4.	0)15	25
	C+	ate	31. Date filed (Month, Day, Year)	32. Registra	r's Signature	100	INCK	4 7	1 -	DAC	14.10.50	J M	y -12	23
	Regist		MAR 1 7 200	4 / 300	a de	most	F							

			For State	State of Maryla		artment of H				08503
			Registrar 1. Decedent's Name (First, Middle,	Last)		tineate or		Reg. N 2. Date of Death	0. —	3. Time of Death
п	Physicia	an	Daniel	LEO	1	stan	7-01	Month	ay Yeer	2:10 PM
	/Medic		4a. Fecility Name (If not institution,			/	or Location of Death		c. County of Death	0.70
	Examin	er	THE TULNIS	HOUNDS 140	SPITAL	Bur	MORE (121		
	Funeral		5. Social Security Number		s. last birthday)	If Under 1 Year	If Under 24 Hrs.	B. Date of Birth (Month Day, Year	9. Birthp	place (State or Foreign
	Director		219-28-2264	1 X M 2□ F 71	Yrs.	Months Days	Hours Min.	August 8,	1932 Mar	yland
	D		Usuel Residence of Decedent		O:- T					Od Jasida City Limite
	irylar show		10a. State 10b. County		City, Town or Lo				[]	1 ☐ Yes 2 X No
	Ba-f s	cto	Maryland Worce	ester	Ocean C			1		
	vith th	Director	10e. Street and Number	70 70t 2C		10f. Zip Code			itizen of What Cour	ntry?
	within 72 hours after death with the Maryland ene. than 'natural', or items 23s or 28s-f show ha Medical Exercitual the incilling at	rai	2813 Plover Driv	12. Was Decedent Ever in	116 123	21842	Hispanic Origin? (Spec	USZ	14. Race - Americ	an Indian
	ter de	Funerai	11. Marital Status 1 Never Married 2 Married	Armed Forces?	0.3.	f Yes, specify Cub	an, Mexican, Puerto R	ican, etc.)	Black, White,	
36	urs af	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates: Kore	aan	1□ Yes ሺ No	Specify:		Specify: Wh	ite
ŏ	2 hou	ted	15. Decedent	s Education	16a, Deced	dent's Usual Occup	nation during most of working	16b.	Kind of Business/In	dustry
2	hin 7 n n Med	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	d)			
2	giene giene er the	Con		4	Metal.	lurgist			teel Manu	facturer
<u>n</u>	be filed tal Hygie d other	Be	17. Father's Name (First, Middle, L				18. Mother's Name	4-		
Maryland 21215-0036	should the marker amarker amarker amarker	2	Anthony Pet				Jeanette	u/k	Fratta	
a	2 sh and Is m raum		19a. Informant's Name/Relationsh	ip (Type, Print)	1 22	3	and Number or Rural			
	l and feelth im 27 her tr			anza/wife	281.	3 Plover	Drive. Apt	3C, Oce	City,	MD 21842
more,	Pages 1 Tent of H Int: If Ite Iny or ot		20a. Method of Disposition 1 X Burial 2 ☐ Cremation	3 ☐Removal from State	cemetery, crer	natory`or other pla	ce)			
Ë	nit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan artment of Heelth and Mental Hygiene. ortant: if Item 27 is marked other than "natural", or Items 23a or 28a-1 show injury or other traumatic event, the Medical Exercities must be indiffied at injury or other traumatic event, the Medical Exercities inside the indiffied at 8.		`4 □Donation 5 □ Other (Sp			L Cemete: Name and Addre		16,2004	havre de	Grace, MD
Balti	permit. Pages 1 and Department of Heels Important: If Item 2 any injury or other 2008.		21. Signature of Juneral Service L	Megas	1 2 2	Comas Fi		'Abingdor		
p			23a. Part1. Enter the disease, or	complications that caused the de		31/ Cokes	Soury Road,	'Abingdor respiratory arrest.	1, MD 210	009 Approximate
			shock, or heart failure. List of Immediate Cause (Final	only one cause on each line.			Λ	t a		Interval Between Onset and Death
}	Physician /Medical		disease or condition resulting in death)	a Commun Due to (or as a cons	1	cquire	a pheun	10ma		7 days
a 3	Examiner			A ch	1	10 100	Fant	120	F	months
	W 8	er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a cons	equence of):	1.65	0			
	uted	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c. ====						
ó	an ar rrial-tr	EX	resulting in death) Last	Due to (or as a cons	equence of):					
8760,	cate be executed physician and the burial-transit	dicai		d						
9	artifica ing pl	Med	IF FEMALE:							
Box	ath ce ttend or us	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pred 1 Live birth 2 F	etal death 3	Ectopic pregnanc	у		23d. Date of delive Month	ery Day Year
	e dea the a	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at time of 9☐ Unknown	of death 5∟	Other (specify) _				
P.0.	The law requires that the death certific tie has been signed by the atlending p bage 2 should be detached for use as i	F.	Part II. Other significent conditio	ns contributing to death but not i	resulting in the u	ndertving cause gr	ven in Part I.	23e. Did tobacco	use contribute to the	he cause of death?
ds,	signed del	d by						î y Yes	2 No 3 Prob	pably 4 Unknown
Ö	w requir been si should	ete						24a. Was an	24h Were auto	ppsy findings available
Re	has ge 2	Completed						autopsy performed?	prior to co death?	mpletion of cause of
B	ician: The certificate rector, pag	e Co	25. Was case referred to medical				26. Place of Death	Chack ask and	lo 1	2 No
of Vital Records,	Physician: r this certificated director,	To B	examiner? 1 ☐ Yes 2 ▼No	Hospital:	☐ ER/Outpatier	nt 3 DOA Ot	nor:	e 5 Residence	6 ∏Other (Specif	'v)
0	g Phys er this eral dii		27. Manner of Death	28a. Date of Injury	28b. Time o			3d. Describe how inj		,,
Ö	Attending r death. ector: Afte by the fune	atio	1 Natural 5 Pending 2 Accident Investig	ation	, injury		Yes 2 □No			
Division	l or Attending I after death. Director: After I in by the funer	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi		t home, farm, str	eet, factory, office	28	3f. Location (Street a City or Town, Sta		I Route Number,
	ital o rrs aft ral Di								·	
	Hosp 24 hou Fune felly fill	Medical	(Check only 2 Medical I	g Physician: To the best of my in Examiner: On the basis of exam						
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Med	one) 29b. Signature and title of certifier	and manner stated.		29c. Licen	se number	29d. D	ate signed (Month,	Day, Year)
)	8 ∓ € ∓		Marial	Lupta, Medie	al Doct	or RE	5-000	Mar		
	X,		30. Name and address of person							
	10		Rajesh Gupta	who completed cause of death (I The Johns H	opkins H	tospital,	600 N. Wolfe	St., Bal	timore, Mi	78ek
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Sig	gnature	,				
	Regist	rar	MAR 1 7 20	04 German	B,	Sparker				

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 05pm Month **Physician** Mary Carter 2004 (nmn) March /Medical 4a Fecility Name (If not institution, give street end number) 4b. City, Town or Location of Deeth 4c. County of Death Examiner 5. Social Security Number If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthdev) #. Date of Birth (Month, Dev. Yeer) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 X F Yrs. 100 230-74-2667 Director 1904 North Carolina Usuel Residence of Decedent the Marylend 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits th end Mantal Hygiene. ?? Is marked other than "natural", or flems 23a or 28e-1 ehov traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No by Funeral Director Maryland Harford Joppa 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 end 2 should be filed within 72 hours efter death with 501 Charmuth Court 21085 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Maritel Status 1 ☐ Never Merried 2 ☐ Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: White Specify: 3₺ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jeff Davis Bullock Rachel (nmn) Hillard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 end 2 Department of Health e Important: if Itam 27 is any injury or other tra John N. Carter, Jr. - Son 501 Charmuth Ct., Joppa, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ⊠ Burial 2 □ Cremation 3 ⊠ Removal from State Calvary Cemetery 3-22-04 Norfolk, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, Maryland 21009 a state death. Do not enter the mode of dying, such as cardiac or respiratory arrest, inch ine. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complication shock, or heart failure. List only one. Physician Immediate Ceuse (Final disease or condition resulting in death) /Medical Examiner Due to (or es a consequence of) Examine use as the buriel-transit The law requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the burie Physician/Medical Due to (or as a consequence of): eta has been signed by the a page 2 should be detached t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 (No 3 Probably 4 Unknown Completed by 24a. Was an autopsy performed? 24b. Were autopsy findings completion of cause of death? 2 X9No 1 ☐ Yes 2 ☐ No 1 Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: ို 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 4 Noursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3□ DOA this eral Director: After this filled in by the funeral 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 5 Pending 1 Naturel investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D edical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner steted. 29c. License number 29b. Signature end title of certifier 29d. Date signed (Month, Day, Year) 1 WM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print W 31. Date filed (Month, Day, Year) 32. Registrer's Signature State

DHMH 16 Rev 6/95

Registrar

2004

State of Maryland / Department of Health and Mental Hygiene 2004 08505 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 15, 11:55 a M Dilley March 2004 Kathryn /Medical Mary 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wesley House Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Sept. 9, 1918 Birthplace (State or Foreign Country) **Funeral** 1□M 2⊠F 85 236 26 3720 Yrs. West Virginia Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28e-f show the Medical Examiner must be notified at Maryland | Baltimore 1 ☐ Yes 2 No Essex Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1008 N. Marlyn Avenue 21221 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: White Specify: þ 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) 9 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be f and Mental I is marked Wheeler John Gresham Bess Jane Lynch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
eny injury or other trau 325 Dark Head Rd. Baltimore, Md. 21220 Donna Marie Dilley-Large (Daughter) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 3/16/2004 * 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory Baltimore, Maryland 22. Name and Address of Facility
Bruzdzinski Funeral Home P.A.
1407 Old Eastern Avenue Essex, Min 23a Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest spock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) END STAGE ALZHETMERS **Physician** DISCHSE /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) o ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Records, PROGRESSIVE RENAL INSUFFICIENCY 3 ☐ Probably 4 Dunknown 1 ☐ Yes 2 ☐ No neral Director: After this certificate has been si filled in by the funeral director, page 2 should Completed CEREBRO VASCULAR ERTENSIVE 24a. Was an autopsy performed? 1 ☐ Yes 2 X No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No Division of Vital Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 🗙 No ို 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: or Attending 1. Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D Hospitel 29a. Certifier 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ٤. D-19425 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WIROGERS AVE-BALTIMORE MD M.D. - 2211 ROBY 92. Registrar's Signature Registrar

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** George Emanuel Dressel, III MARCH 6:2121 A M 2004 15, /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Saint Joseph Medical Center Towson Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Pay, Year, Aug. 16, 1 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 1 M 2 □ F 218-46-3596 Arkansas 58 1945 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow ?7 is marked other than "neturel", or items 23s or 28s-f sho: treumstic event, the Madical Examins maint be mutified at Director Maryland Baltimore 1 ☐ Yes 2 ☑ No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10116 Fontaine Drive U.S.A. 21234 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel", or item any injury or other treumatic event, the Mental or other treumatic event, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give 1 ☐ Never Married 2 🕅 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: White. 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore Gas & Electric Co. Elementary/Secondary (0-12) College (1-4or 5+) Lab Technician 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Dressel, Jr. Mildred George Emanuel Sartain L. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Barbara A. Dressel (wife) 10116 Fontaine Drive, Baltimore, MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 □ Cremation 3 □ Removal from State Parkwood Cemeteru * 4 ☐ Donation 5 ☐ Other (Specify) 3/20/2004 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Homes 9705 Berair Rd., Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician SEPSIS HOURS /Medical resulting in death) Due to (or as a consequence of): Examiner PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ should be 1 🗌 Yes 2**X** No 3 Probably 4 Unknown Completed 24a, Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate has funeral director, page 2 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 npatient 3□ DOA 2 ☐ ER/Outpatient this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 Natural 2 Accident 5 Pending Injury death. 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 0060495 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OSLER DRIVE. TOWSON, MARYLAND 21204 FAN. M.D. 7601 7HEN 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2004

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	and *	-	Usual Residence of 10a, State	Decedent 10b. County		10c. Cit	y, Town or Lo	ocation					1	0d. Inside City Limits
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8760,	te be ysicie ie bur	dical Examiner	Immediate Cause (disease or condition resulting in death) Sequentially list conif any, leading to imcause. Enter Under Cause (Disease or ithat initiated events resulting in death) L	nditions, mediate rlying njury	a. Due to b. Due to c. Due to d. EW	(or as a conseq (or as a conseq (or as a conseq (or as a conseq	uence of):	CEX ZICL MEC REN,	47	TUS	E AS	Ê		Onset and Death
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A Division of Vital Records,	el or Attendi s after death. Il Director: A id in by the fu	Certification;	3 ☐ Suicide 4 ☐ Homicide	6 Could not determine	d 286. Plac	e of Injury - At he ling, etc. (Specif	ome, farm, st	reet, factory,	office		28f. Location (Si City or Town		ımber or Rura	al Route Number,
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State of Maryland / Department of Health and Mental Hygiene, 0.04Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year Physician 2004 9:55 March 8, A^{M} Helen Shorb Delaplaine /Medical 4c. County of Death 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 308 Upper College Terrace Frederick Frederick If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months 1 ☐ M 2 🖔 F Hours 97 1907 Maryland Director 213-40-2909 Usual Residence of Decedent within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 X Yes 2 No Director Maryland Frederick Frederick 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21701 USA 308 Upper College Terrace Funera Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No If Yes, Give Year or Dates: Specify: Specify: þ 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) nould be filed within I Mental Hygiene. 12 public school system teacher 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be Laura Shorb Ernest David Michael 2 item 27 le ma 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 305 Rockwell Terrace, Frederick, MD R. Dean Stickell, son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any injury or ot 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Smithsburg Crematory 3/8/2004 Smithsburg, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Keeney and Basford Funeral Home 21. Signature of Funeral Service Licensee 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, dr heart failure. List only one cause on each line. M00999 106 East Church Street, Frederick MD 21701 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** years <u>Cerebrovascular Disease</u> resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Due to for as a consaquence of ner cause. Enter Underlying Cause (Disease or injury that initiated events certificate be executed burial-transit Exami and resulting in death) Last Due to (or as a consequence of) Box 68760, attending physiciar Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. detached the 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ of Vital Records, 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 🗓 No should should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an s certificate has t director, page 2 s mea / 2 **∆** No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 2 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Director: After Injury Division 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident completely filled in by the I 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L To the Hospital 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D30496 March 8, 2004 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 300 West 9th Street, Frederick, Maryland Francis E. Becker, MD, 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 7 2004 Registrar

	Certificate of Death Reg. No. 20	08509
Physicia	1. Decedent's Name (First, Middle, Last) Stanley Noel Dunn, Sr. 2. Date of Deeth Month Day Ye March 13, 2004	
/Medica	45 City Town or Location of Dooth	1:55 a.m.
Examine	Washington Adventist Hospital Takoma Park Montgo	
Funeral Director	5. Social Security Number 577-32-6918 6. Sex 12 M 2 F 7. Age (In yrs. lest birthdey) 13 M 2 F 75 Yrs. 7. Age (In yrs. lest birthdey) 15 Under 1 Year 1f Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec. 15, 1928	Birthplace (State or Foreign Country) New York
dend a	Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
e Many	Maryland Prince George's Hyattsville	1⊠ Yes 2□ No
th with the 23a or 28	10e. Street end Number 4008 Quintana Street 10f. Zip Code 10g. Citizen of Wha 20782 U.S.A.	t Country?
Baltimore, Maryland 21215-0020 parmit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health end Mentel Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show eny injury or other treumatic event, the Medical Exeminer must be notified at once.	1 □ Never Married 2 ☒ Married 1 □ Never Married 2 ☒ Married 1 ☒ Yes 2 □ No 1 ☒ Yes 2 □ No 1 ☒ Yes 2 □ No 1 ☒ Yes 2 ☒ No Specify: Specify:	American Indian, Vhite, etc. White
n 72 h	15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Busine (Give kind of work done during most of working life. DO NOT use retired) Bureau 0	•
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Baltimore, samit. Pages 1 er appartment of Hea mportant: If Item: my injury or other more.	20a. Method of Disposition 1 Burial 2 MiCremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory 3/17/2004 Alexandria	or Town, State
Baltimore parmit. Pages 1 Department of I- Important: if its eny injury or ot	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville	
	23a. Part tenter the disease, or complication at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between
Physician /Medical Examiner	Immediate Ceuse (Final disease or condition resulting in death) ACUTE Respiratory Failure	2 hours
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68760, ifficate be executed g physician end es the burial-transit	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	
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P.O. I at the ded by the a detached f	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I.	
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of Vital Records, P.O. Box Physician: The law requires that the death cer this certificeta has bean signed by the attendin rel director, page 2 should be detached for use		lb. Were autopsy findings available prior to completion of cause of death?
	1□ Yes 2 No	1 ☐ Yes 2 No
Vision of Vital I Attending Physician: The office that the certificets by the funerel director, page 1487-2410 of 1487-241	25. Was case referred to medical examiner?	
Physical direction	1 Inpatient 224EH/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 I Other (S	ipecify)
onding Freth. or: Aftar ha funer	Total ture 5 □ Pending (Month, Dey Year) Injury Work? 2 □ Accident investigation M 1 □ Yes 2 □ No	
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n 24 hour no 24 hour no Funer pletaly fill	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner one investigation, in my opinion, death occurred at the time, date and place, and manner stated.	as steted. due to the cause(s)
with Tot	29b. Signature and title of certifier 29c. License number D12582 March 1	
1511	30. Name and address of person who completed cause of deeth (Item 23a) (Type Print) 7600 Carroll Avenue Takovna Park, MD 23912	
State Registra	SULD 1 / 2004 N	
DHMH 16 Rev 6/95	reported.	

State of Maryland / Department of Health and Mental Hygiene For State Registrar 08510 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3 **Physician** DODA 2:37 AM RICHARD M 04 10 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ARNUSEL ANNE NORTH ARUNDER HOSPITAL Glen Burnie 7. Age (In yrs. last birthday)
57 Yrs. 5. Social Security Number 214-44-3619 If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Mary Land Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County or 28a-f show Maryland Anne Arundel Glen Burnie 1 ☐ Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 132 Glen Rd. 21060 United States Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 □ No Viet If Yes, Give Year or Dates: Nam Era Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: WH17E þ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: if Item 27 is marked other than 'na sny injury or other traumatic avant, the Madic 2008. Elementary/Secondary (0-12) College (1-4or 5+) Warehouseman Tire Distribution 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Milton Doda, Sr. Sally Glinka 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Brenda Y. Kenney Doda / Wife 132 Glen Rd., Glen Burnie, Maryland 21060 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition March 13 1 Burial 2 Cremation 3 Removal from State Metro Crematory, Inc. Catonsville, Maryland * 4 □ Donation 5 □ Other (Specify) 2004 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Kirkley-Ruddick Funeral Home, P.A. 421 Crain Hwy., S.E., Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) FIBRILLATION VENTRICULAR **Physician** MINUTES /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Uncertain Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Box 68760, attending physician Hospital or Attending Physician: The law requires that the death certificate be Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4 Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ HYPERTENSION 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate 2 **X** No 1 Yes 25. Was case referred to medical examiner?

1 Pres 2 No 26. Place of Death (Check only one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 X ER/Outpatient 3 □ DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury 1 Watural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Diractor: A 2 Accident investigation 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Carridying Physician: To the best of my knowledge death occurred at the time, date and place and due to the cause(s) and manner as stated.

[Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of contifie 029807 3/11/04 Tru 30. Name and address of person who tompleted cause of death (Item 23a) (Type, Print) 1406 S.CRAIN HWY. GLEN BURNIE MID 21061 SuitE 106 M,S CAPLOS D. ZIGEL 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 1 7 2004 Registrar

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Registrar

			- State Amend Item #2	State of Maryland Ob per in 6830	/Depa Cer	rtment of Health and I 14 Eas tificate of Death	Mental Hygie	ne 2004	08512
rjo	Physici	107	Decedent's Name (First, Middle, Last				2. Date of Death Month	Day Year	3. Time of Death
2	/Medic	al	Leo L. Evans 4a. Facility Name (If not institution, give	etroot and number)		4b. City, Town, or Location of Deatl	MARCH	10 2004 4c. County of Death	100011
	Examin	er	Doctor's Communit			Lanham		Prince Ge	orge's
	Funeral Director		5. Social Security Number 6. Se		st birthday) Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yo Jan. 14,		lace (State or Foreign htry) ansas
	p		Usual Residence of Decedent 10a, State 10b, County	10c. City.	Town or Lo	cation		1	Od. Inside City Limits
	shov	ō				lege Park			1 ☐ Yes 2 ☐ No
	28a-1	rect	Maryland Prince (10e. Street and Number	1601 gc 3	001	10f. Zip Code	10g	. Citizen of What Cour	itry?
	3a or	i Di	6012 Westchester	Park Drive		20740		U.S.A.	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Itam 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Evan are modified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Nas Decedent of Hispanic Origin? (S f Yes, specify Cuban, Mexican, Puer t □ Yes 2 X No Specify:	pecify Yes or No- to Rican, etc.)	14. Race - Americ Black, White, Specify: B1a	etc.
ğ	72 hou	ted	15. Decedent's Ed (Specify only highest grad	ication	16a. Dece	dent's Usual Occupation kind of work done during most of wo	rking 16	b. Kind of Business/In-	dustry
215	thin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired) ice Officer		niversity Of	f Maryland
2	led w lygier her th		17. Father's Name (First, Middle, Last)	1	POL		me (First, Middle, Ma		
and	l be fill ntal H ad otl	Be	Leo Evans			Glad			
Maryland	should nd Me mark imark	2	19a. Informant's Name/Relationship (7	ype, Print)		ng Address (Street and Number or R			Code)
Z	alth a		Bettie Lathan - A			N. 40th Avenue,		68111	
Baltimore,	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than 's rany injury or other traumatic event. If a Magnes.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☑ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State	or y G	sition (Name of natory or other place) irden Cemetery 3/1	9/2004 н	c. Location · City or To ope, Arkan	sas
Balti	permit. Departn Imports sny inju		21. Signature of Funeral Service Licen	see Hase		2. Name and Address of Facility ${\sf Ga}$			
	Physician /Medical Examiner	er	23a. Part1. Enter the disease, or compshock, or heart failure. List only timmediate Cause (Final disease or condition resulting in death)	b	ATIC lence of):	er the mode of dying, such as cardia	c or respiratory arrest		Approximate Interval Between Onset and Death
68760,	ficate be executed physician and is the burial-transit	edical Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequent	uence of):				
. Box	it the death certific by the attending p tached for use as	by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of deliv Month	ery Day Year
ds, P.O	uires that the signed by does detact		Part II. Other significant conditions of	ontributing to death but not resu	ulting in the u	inderlying cause given in Part I.	23e. Did toba 1 ☐ Yes	cco use contribute to t 2 ဩNo 3 □ Proi	
Division of Vital Records,	Attending Physician: The law requires that the death certificate in death. r death. ector: Atter this certificate has been signed by the attending phys by the funeral director, page 2 should be detached for use as the	Completed						prior to co death? No 1 ☐ Yes	opsy findings available ompletion of cause of
Vita	iician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:	EDIO.4	Other	eath Check onl. one	ce 6 ☐Other (Speci	fv)
ot	Phys r this ral dii	- T	1 Yes 2 No	28a. Date of Injury	28b. Time o	nt 3 DOA 4 Ndrsing	28d. Describe how		97
O	ding I th. : After s funer	tion	1 Natural 5 Pending 2 Accident Investigatio	(Month, Day Year)	Injury	M 1 ☐ Yes 2 ☐ No			
Divisi	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the t	Medical Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury · At he building, etc. (Specify	ome, farm, si	reet, factory, office	28f. Location (Stre City or Town,	et and Number or Rur State)	al Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct corribletely filled in by	dical C	29a. Certifier Check only one) Certifying Ph	nysician: To the best of my kno niner: On the basis of examina and manner stated.	wledge, dea tion and/or i	th occurred at the time, date and place overstigation, in my opinion, death occurred.	e, and due to the cau curred at the time, dat	ise(s) and manner as s e and place, and due t	stated. to the cause(s)
)	To the within 2 To the comple	Me	29b. Signature and title of certifier	MD-		29c. License number	290	Date signed (Month)	Day, Year)
	7		30. Name and address of person who	completed cause of death (Item	n 23a) (Type	Print) 630/ area	VBELT !	CORD U	*3
		tate	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature	4		(
	Regis		MAR 1 7 200	Bensen	19	fra 6			
. U	HMH 17 Rev 1.	/2001				*			

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		•	1 - For State Registrar	State of Marylar	nd / Depa	artment o	of Health and of Death	Mental Hy	giene Reg. No.	2004	08514
			1. Decedent's Name (First, Middle, Las.	0				2. Date of De	ath	Vaar	3. Time of Death
	Physici		Vincent V	Faraino				MARLE	Day	7604	12:05 PM
>	/Medic Examir		4a. Fecility Name (If not institution, give			4b. City, Tov	vn, or Location of Dea			County of Death	
***			Baltimara Rebab	litation Extern	ed Cinx		Baltima	7-6-	Ва	altimore	City
	Funeral		5. Social Security Number 6. Se	7. Age (In yrs.	last birthday)	If Under 1 Y	ear If Under 24 Hrs ays Hours Min	. (Month, Da	th ay, Year)	9. Birth	plece (State or Foreign ntry)
	Director			[™] ^{2□ F} 91	Yrs.			Novembe	r 23	1912 Balti	more, Maryland
	and		Usual Residence of Decedent 10a, State 10b, County	10c. Ci	ty, Town or Lo	ocation					10d. Inside City Limits
	Aaryl sho	ō	Maryland Baltimore	Pol-	timore C	or mater :					1 Yes 2 No
	28a-	Director	10e. Street and Number		undre C	10f. Zip Co	de		10g. Citiz	zen of What Cou	ntry?
	d within 72 hours after death with the Maryland Jione. I'r then "natural", or Items 23a or 28a-f show I'ne Medical Examinar must be nutified at		49 Yew Road			21221			USA		
	ter death	Funerai	11. Marital Status	12. Was Decedent Ever in U		Was Decedent	of Hispanic Origin? (Specify Yes or No		14. Race - Ameri	
ယ္	or Ite	F	1 Never Married 2 Marned	Armed Forces? 1 □Yes 2 □ No If Yes, Give			Cuban, Mexican, Pue	to Hican, etc.)		Black, White,	etc.
9	ral', c	by	3 X Widowed 4 ☐ Divorced	Year or Dates: WW		1 ☐ Yes 2 🔀	No Specify:			Specify: Whi	te
5-0	72 h	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)	(Give	dent's Usual O	one during most of wo	orking	16b. Kir	nd of Business/In	ndustry
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and	B a b ≥	Be	17. Father's Name (First, Middle, Last)					me (First, Middle	, машеп	Sumame)	
3	N T T	2	Glovanni. Faraino 19a. Informant's Name/Relationship (7	inna Oriesti	10h 14a:E	4 /0/	Rosaria Treet and Number or R		0:4	Town Chair To	- Code)
Maryland 21215-0036	d 2 h a 7 is	li	Marie F Biegun	ype, Finity		COLUMN TO A COLUMN	Avenue Balt				O COGE)
	Hear Hear the		20a. Method of Disposition	20b. I		osition (Name of matory or other		Date Date	-	cation - City or To	own, State
5	of of		1X Burial 2 ☐ Cremation 3 ☐	Removal from State	_		Merch 19 200	ν,	Pol+i	moses Moses	land
Baltimore,			4 □ Donation 5 □ Other (Specify21. Signature of Funeral Service License				ddress of Facility	4	Daru	more, Mary	Iaru
Ba	permit. Departr Importa eny inju		Mayor Coco	The Obrance	L. L	assahn Fl	meral Home 1	Inc ,		M 000	
7%			23a. Part 1. Enter the disease, or comp	lications that caused the dear	th. Do not ent	er the mode of	ir Road Balti dying, such as cardia	more, Mary.	rrest,	1236	Approximate
	Dhusisian		shock, or heart failure. List only of immediate Cause (Final								Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Gange	neuce ot).						weeks
	Examiner					1.	Diesis				VIa. a.
		Jer.	Sequentially list conditions, if any, leading to immediate	b. Per.ph.sal	juence of):	1101	0,7,00				1157
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o o	e exe ian ar irial-t		resulting in death) Last	Due to (or as a consec	quence of):					Ţ	
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a		င္ပ	25. Was case referred to medical					1 ☐ Yes	2 No	1 🗆 Yes	2 No
Ξ	- B B	o Be	examiner?	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatier	nt 3 DOA	Other -	ath (Check only only only only only only only only			4.1
of			1 Yes 2 No 27. Manner of Death	28a. Date of Injury	28b. Time o	-	Injury at Work?	28d. Describe			TY)
O	th: : Atter s funer	tlor	Natural 5 Pending 2 Accident Investigation	(Month, Day Yeer)	Injury	М	Work? 1 ☐ Yes 2 ☐ No				
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Ö	s afte	Certification:	4 🗆 Normolde	building, etc. (Special	'y)			City of Tol	wii, Siale)		
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	edical (29a. Certifier Certifying Physical Exem	sicien: To the best of my knowiner: On the basis of examina	owledge, deat	h occurred at the	ne time, date and plac	e, and due to the	cause(s)	and manner as s	stated.
	the hin 24 the F	Medi	one)	and manner stated.							
	To To Cor	-	29b. Signature and title of certifier	la-			cense number	3		signed (Month,	Day, rear)
	112		Joh H	α	- 00() (T		00350	55	Men	ch 15	2004
	1/1		30. Name and address of person who o	completed cause of death (Iter	п 23а) (Гурв,	Print))	11.8		www	71715
	Sta	ite	31. Date filed (Month, Day, Year)	32 Registrar's Signa	ature /	and b	Bouleveril	1 JOHE !	76-2	1111)	6.618
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		•	For State Registrar	State of Ma		epartmer Certificat			ind M		giene ,	2004	08515
	Physicia	an	1. Decedent's Name (First, Middle, Last)	Constant						2. Date of De Month	ath Day	Year	3. Time of Death
	/Medic	al	Joseph Anthony 4a. Facility Name (If not institution, give st	GWYET		4b City	Town, or	Location o		March	4c. Co	2004 ounty of Death	9:45 P M
	Examin	er	1099 N. Tollgate			1	el Ai					Harkon	
	Funeral Director		5. Social Security Number 6. Sex 219-01-3804		(In yrs. last birtl		r 1 Year		Min.	8. Date of Bir (Month, Da Nov. 3	th y, Year) 1918		place (State or Foreign intry) LYLand
-	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23a or 28a-f show aumatic event, the Wedleal Erants est must be notified at	Funeral Director	Usual Residence of Decedent 10a. State 10b. County Maryland Harford 10e. Street and Number		10c. City, Town	Bel A	ir Code				10g. Citize	n of What Cou	10d. Inside City Limits 1 ☐Yes 2 ☐ No
	23a c	alD	1099 N. Tollgate	Road	_			1014				.S.A.	
936	urs after dea	by	11. Marital Status 1 Never Married 2 X Married 3 Widowed 4 Divorced	2. Was Decedent E Armed Forces? 1 XYes 2 N If Yes, Give Year or Dates:		13. Was Dece If Yes, spe		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto l	cify Yes or No Rican, etc.)		. Race - Ameri Black, White pecify: Wh	
Manuard 21215_0036	within 72 hours jiene. r then "natural", the Wedleal Ex-	Be Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)			Decedent's Usu (Give kind of wo life. DO NOT U	ork done d se retired	turing most	of worki	ng		of Business/Ir	
and 9	and 2 should be filed within a 2 should be filed within and whental Hygiene. I amarked other than other traumatic avent, thank	To Be Co	17. Father's Name (First, Middle, Last) John A. Gwyer	4		reache	L			(First, Middle	, Maiden St	ımame)	. 10003
Mon	nd 2 should be 1 lith and Mental 1 27 is marked o	Ţ	19a. Informant's Name/Relationship (Typ Mrs. Melva Gwyer	e, Print) (Wife)		Mailing Addres							
9	es 1 au of Hea of Heam if item		20a. Method of Disposition 1 Burial 2 Cremation 3 Re	moval from State	20b. Place of cemeter)	Disposition (Na y, crematory or	me of other plac	e)	D	ate	20c. Loca	tion - City or T	
	permit. Pages 1 and 2 a Department of Health ar Importent: If item 27 is any injury or other trau		4 □ Donation 5 ☑ Other (Specify) € 21. Signature of Funeral Service License	ntombmen	t Garder					/2004 imunek			
à		1 1	Buen Ce L	ulle	~	9705	Bela	ir Ra	l., B	saltimo.	re, MI	2123	6
6 D	Physician /Medical		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each-lin	no. Rostu	tur		g, such as		r respiratory a	rrest,		Approximate Interval Between Onset and Death
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3/12/04	death certificate be executed eathoriticate be executed eatherding physician and for use as the burial-transit	I Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a consequence o	of):							
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infer of the	the death certifica by the attending ph	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ic. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal death	3 □Ectopic p 5 □ Other (s					230	d. Date of deliv Month	rery Day Year
	es tha	b	Part II. Other significant conditions con	ributing to death be	ut not resulting in	the underlying	cause give	en in Part I.			obacco use Yes 2 🗆		the cause of death?
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700	To the Hospitel or Attenwithin 24 hours after deat To the Funerel Director: completely filled in by the	edical C	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of er: On the basis of and manner sta	examination and	, death occurred Vor investigation	at the time, in my of	ne, date an pinion, dea	d place, a	and due to the ed at the time,	cause(s) ar date and pl	nd manner as lace, and due	stated. to the cause(s)
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State of Maryland / Department of Health and Mental Hygiene 2001 08516 State Registra AMEND I EM #2 PER PHY G830 4/08/04 JG ertificate of Death 2. Date of DeathMAR 11, 2004 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day **Physician** 2004 McCray Gentry March 2218 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 1 Q M 2 □ F 237-26-7389 85 May 31, 1918 North Carolina Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or other traumatic event, the Mudical Examiner what he notified at 1 ☐ Yes 2 ☐ No X Director Md. Harford Fallston 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5 1820 Abelia Road United States 'natural', or items 23a Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 XYes 2 No If Yes, Give Year or Dates: ↓ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: white ģ 3 Widowed 4 Divorced WWII Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, Ite Ma 2008. College (1-4or 5+) Elementary/Secondary (0-12) repairman steel mill 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) Be Andrew Jackson Gentry Letishia Wallin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Dennison/granddaughter 1820 Abelia Road, Fallston, Md. 21047 20b. Place of Disposition (Name of cemetery, crematory or other place)
Chapel Hill Baptist
Church Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 TRemoval from State Marshall, N.C. * 4 ☐ Donation 5 ☐ Other (Specify) 3/16/04 22. Name and Address of Eachlity
Schimunek Funeral Home of Bel Air, Inc. 21. Signature of Funeral Service Licensee 610 W. MacPhail Road, Bel Air, Md. 21014 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician -ongestive /Medical Due to (or as a consequence of): Examiner ORONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Box 68760. attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0 the 9 Unknown 9 Unknown been signed by should be detacl Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by FAILURE 3 ☐ Probably 4 ☐ Unknown 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perfo luneral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes ٩ 3 DOA 1 npatient 2 ER/Outpatient vision of 28c. Injury at Work? Certification: Manner of Death Time of 28d. Describe how injury occurred 28b. 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A investigation completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Examiner: On the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29b. Signature and title of Certifier (Item 23a) (Type, Print) who complet 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 7 2004 DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2004 Certificate of Death 2 Date of Death 1. Decedent's Name (First Middle, Last) 5:24PM MARCH **Physician** /Medical 4b. City, Town, or Location of Death 4c. County of Deeth Examiner OWSON If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** 1927 PENNSYLYANIA Days 1 M 2 Hours Months Director Usual Residence of Decedent the Maryland 10c. City Town or Location 10d. Inside Oty Limits 10a. State 10b. County 28a-f show the Medical Exertimer must be notified at MI BALTIMORE 1 Nes 2 No Director 10g. Citizen of What Country? 10f. Zip Code ö U.S.A. "natural", or Itama 23a Be Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 1 Never Married 2 Married Specify: BLACK 21215-0036 1 Yes 2 No Yes, Give 'ear or Dates: Specify 3 ₩idowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) DRIVATE DOMESTIC is marked other 18. Mother's Name (First, Middle, Maiden Sumame) Maryland 17. Father's Name (First, Middle, Last) WILLIAM ELLIOH 1 and 2 should be Health and Merital ANNIE MAE 19b. Mailing Address (Street and Number or Rural Rout Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) TRAMORE ROAD BATIMORE, MD 21214

On (Name of Date 20c. Location - City or Town, State SON Pages 1 and 2 nent of Health a ant: If item 27 is or other Baltimore. 20b. Place of Disposition (Name of 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

WEST NEWTON CEMETERY 3.20.04 HORELAND COUNTY PENNS WINA

22. Name and Address of Facility VAUGHIN C. GREENE FUNDER HOME 1 ☐ Burial 2 ☐ Cremation 3 ☑ Removal from State pernit. Page Depirtment o Important: If i *4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Pert1. Enter the disease, or amplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** OVARIAN CANCER /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner that initiated events resulting in death) Last burial-tran Due to (or as a consequence of) the attending physician Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ of Vital Records. 1 Yes 2 No 3 Probably 4 MUnknown Be Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 1 ☐ Yes 2 XNo HOSPICE 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Division 1 Natural 2 Accident 5 Pending 1 Yes 2 No death. investigation after death illed in by the 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a 29a. Certifie! 🖹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 93

State Registrar

n

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

32. Registrar's Signature

16.00

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TARIO MAHMOOD

	1	State of Maryland / Depar	tment of Health and Nificate of Death	Mental Hygier	
Physicia /Medica	n	1. Decedent's Name (First, Middle, Last) FRANK J. HENNEMAN, SA		2. Date of Death Month MARCH 15	Day Year 10:55AM
Examine	r	GALTIMURE REHABILITATION EXTENDED CAPE	4b. City, Town, or Location of Death BALT	IMORE	4c. County of Death
Funeral Director			If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea 01-24-19	ar) 9. Birthplace (State or Foreign Country) 18 MARYLAND
ith the Maryland or 28a-f ahow		10a. State 10b. County 10c. City, Town or Loca MD BALTIMORE	PARKVILLE		10d. Inside City Limits 1 ☐ Yes 🏋 No
th with the 23a or 28a	Funeral Director	10e. Street and Number 6800 COLLINSDALE ROAD	10f. Zip Code 21234	10g. (Citizen of What Country? U.S.A.
(0 0	by Funera	1 □ Never Married 2 □ Married VIVes 2 □ No	as Decedent of Hispanic Origin? (Sp res, specify Cuban, Mexican, Puerto Yes XX No Specify:	pecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: WHITE
within 72 hours ene. than "naturel", he Medicel Exe	Completed	(Specify only highest grade completed) (Give kii	nt's Usual Occupation nd of work done during most of work O NOT use retired) SUPERVISOR	king	Kind of Business/Industry
m - 0 2	To Be Co	17. Father's Name (First, Middle, Last) FRANK G. HENNEMAN	18. Mother's Nam	e (First, Middle, Maid HOLT	len Sumame)
t and 2 should the author of the traumatic		19a. Informant's Name/Relationship (<i>Type, Print</i>) 19b. Mailing JOHN T. HENNEMAN (SON) 5603	Address (Street and Number or Rur 31st. AVENUE, HY		y or Town, State, Zip Code) , MARYLAND, 20782
0 0 = 5			itory or other place)		Location - City or Town, State ALTIMORE, MARYLAND
permit. Pag Department Important: any injury o			Name and Address of Facility JCK TOWSON FUNERA	L HOME, INC	1050 YORK ROAD TOWSON,MD.,21204_
Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death Tyems
Examiner	ler	Sequentially list conditions, frany, leading to immediate Due to (or as a consequence of).			
be executed ician and burial-transit	Examiner	cause. Enter Undertying Cause (Disease or injury that inflated events resulting in death) Last Due to (or as a consequence of):			
tificate be exigonal physician as the buria	fedical	d			
The colins, I.C. DOX 00100, The law requires that the death certificate be executed are has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physiclan/Med		ctopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
faw requires that as been signed be 2 should be deta	ρ	Part II. Other significant conditions contributing to death but not resulting in the und	erlying cause given in Part I.	23e. Did tobacc	ouse contribute to the cause of death? 2 No 3 Probably 4 Muncy
has has	Completed			24a. Was an autopsy performed 1 Yes 2 1	
VICAL F	o Be	25. Was case referred to medical examiner? 1 Tyes 2 No Hospital: 1 Inpatient 2 ER/Outpatient	Other	th (Check only one)	6 □Other (Specify)
3 = 4	atlon: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) 28b. Time of Injury (Month, Day Year)	28c. Injury at Work? M 1 Yes 2 No	28d. Describe how in	
To the Hospital or Attending F within 24 hours after death. To the Funeral Director; After completely filled in by the funer	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury · At home, farm, stree building, etc. (Specify)	it, factory, office	28f. Location (Street City or Town, St.	and Number or Rural Route Number, ate)
To the Hospital or At within ≥4 hours after of To the Funeral Direct completely filled in by	edical	29a. Certifier (Check only one) 1.★ Certifying Physician: To the best of my knowledge, death of the basis of examination and/or investant manner stated.		red at the time, date a	and place, and due to the cause(s)
To t com	M	29b. Signature and title of certifier Amura C. Tan, M. D.	D 14958		Date signed (Month, Day, Year) ROH 15; 2004
10		30. Name and address of person who completed cause of death (Item 23a) (Type, PAUROLA C. TAN 3900 LOCH RAVE) 31. Date filed (Month. Day. Year) 32. Registrar's Signature	N BOULEVARD	BALTIMO	PRE, MD 21218
Stat Registra	ar	31. Date filed (Month, Pay, Year) MAR 1 7 2004 32. Registrar's Signature	Spark		

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year March 14, 2004 **Physician** 5:25 A M Waldemare Hawkins John /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Gilchrist Center Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Months Days Hours Min. 3 11, 11 6. Sex XXM 2□F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 71 1933 Maryland Director 219-28-9604 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28e-f show item 27 is marked other than "netural", or items 23a or 28e-f show other treumatic event, the Madical Examination and be multified at 1 Yes 2 No Directo Maryland Baltimore Lutherville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21093 1602 Bellona Avenue 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 [XYes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Marned カド AM Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry s 1 and 2 should be filed within if Health and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Sales Representative Food Industry 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 2 Hawkins Elvira Nelson William L. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) B. Hawkins Wife 1602 Bellona Avenue Lutherville, Maryland June 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 tment of h 1 ☐ Burial 2 XCremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or once. * 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 3-17-2004 Towson Maryland 21. Signature/of/Funeral Service License 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Towson, Maryland 21204 1050 York Road 23a. Part . Enter the discussed are complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) wonke 4 mpocy ti Physician years /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month jo Day 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ page 2 should be 1 Yes 2 No 3 Probably 4 Striknown Be Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autoosy performed? certificate 2√ No 1 ☐ Yes 2 ☐ No 1 ☐ Yes funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Her (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: or Attending Natural 5 Pending within 24 hours after death. To the Funerel Director: A 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) It Raltimore MD 21204 mo 31. Date filed (Month, Day, Year)
MAR 1 7 2004 32 Registrar's Signature State Registrar

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			1 - For State RegistraAMFND ITEM #20a	State of Mai	yland / Depa	artment of H	ealth and N		2001.	08520
		¥	Decedent's Name (First, Middle, Last)	50 4/12/040	timouto or E		2. Date of Death	NOC. U U M	3. Time of Death
	Physici		Charles	Hunt, D.	D S			Month	Day Year	
1	/Medi Examir		4a. Facility Name (If not institution, give			4b. City. Town, or	Location of Death	MARCH	4c. County of Death	
	LXaiiiii	iei	20 Cedar Avenu			_				
	Funeral		5. Social Security Number 6. Se		(In yrs. last birthday)	If Under 1 Year	SON If Under 24 Hrs.	8. Date of Birth	Baltin 9. Binh	NOFE upface (State or Foreign untry)
8	Director		218-28-9273	₹M 2□F 7	Yrs.	Months Days	Hours Min.	Month, Day, Y		vland
	P _		Usual Residence of Decedent					,y	,,,,,,	y 20110
	show	_	10a. State 10b. County		IOc. City, Town or Lo	cation				10d. Inside City Limits
	Ba-f	Director	Maryland Baltimore	3	Towsor	<u> </u>				1 DYes 2 No
	vith th		10e. Street and Number			10f. Zip Code		10g	g. Citizen of What Cou	intry?
	6 238	Funeral	20 Cedar Avenue			2120			USA	
	ier de Item	n,	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ev Amed Forces?		Was Decedent of His f Yes, specify Cubar	spanic Origin? (Sp n, <mark>Mex</mark> ican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White	
36	rs aft	by	3 Widowed 4 Divorced	1 🖄 Yes 2 🗆 No ff Yes, Give Year or Dates: 1 S	953-55	1□ Yes 2M No	Specify:		Specify:	nite
21215-0036	within 72 hours after death with the Maryland one. than 'natural', or items 23s or 28s-f show ite Maryland Examinet must be notified at	ed	15. Decedent's Edu	cation		dent's Usual Occupa	ition	16	Sb. Kind of Business/Ir	
715	in 7	Completed	(Specify only highest grad Elementary/Secondary (0-12)	e completed)	(Give	kind of work done d DO NOT use retired)	uring most of work	ing	o. raid of businessin	loustly.
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	e filed at Hygi other vent, I	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, Ma		
Maryland	s 1 and 2 should be filed within f Health and Mental Hygiene. item 27 is marked other than other treumatic event, the M.	To	Charles E.	Hunt			Elizab	eth K	(raus	
ar	2 sho and I is ma		19a. Informant's Name/Relationship (Ty	rpe, Print)	19b. Mailin	g Address (Street a	nd Number or Rura	al Route Number, C	City or Town, State, Zij	p Code)
	1 and 2 Health Iem 27 I		George S. Ingalls	/ Attorney	/ 305	W. Chesap			Md. 21204	+
ore		1	20a. Method of Disposition U⊓K 1XXBurial 2 □ Cremation 3 □ F	lomoval from State	20b. Place of Dispo- cemetery, cren	sition (Name of Later)	lnk i	Date UNK 20	c. Location - City or T	own, State Unk
Ĕ	Pa Introduction		'4 □Donation 5 □Other (Specify)	A STATE	CLYNMALIRA	UNITED METH	. CEM. 3,	/08/04 P	HOENIX MARYL	AND
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Fundal Service Uns	88		. Name and Address	•		1050 Yc	rk Road
_	20539		cal f	any!					c. Towson,	Md.21204
100			23a. Part1. Enter the disease, or compl shock, or heart failure. Just only or	ications that caused the	e death. Do not ente	er the mode of dying	, such as cardiac o	or respiratory arrest		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Achoros	deforie	-ARdieVA	SC V/AR"	D. Teast	. (onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):				/	
		-	Sequentially list conditions, if any, leading to immediate	Due to (or as a	consequence of):					
	ted	nlne	cause. Enter Underlying Cause (Disease or injury	Due to (or as a t	orisequence or).					
	and al-tra	Examiner	that initiated events resulting in death) Last	Due to (or as a c	consequence of):					
58760,	cate be executed physician and the burial-transit	dical E		4						
89		edic		J						
Вох	eath certifi attending	Z/M	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of	pregnancy				23d. Date of delive	erv
	0 0	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 4 ☐ Pregnant at tin		Ectopic pregnancy Other (specify)			Month	Day Year
P.0	at the de by the a tached	Physician/Me	9 Unknown	9□ Unknown						
S,	requires that the een signed by th hould be detache	by P	Part II. Other significant conditions cor	tributing to death but	not resulting in the un	derlying cause giver	n in Part I.	23e. Did tobac	co use contribute to the	he cause of death?
ord	w require		WIMONARY CA	NCEK_				1 🗆 Yes	2 12√No 3 □ Prob	pably 4 □Unknown
0	as as as a	ompieted						24a. Was an	24b. Were auto	psy findings available mpletion of cause of
Œ	age age	mo.						autopsy performed	death?	mpletion of cause of
ita	sician: certifica rector, p	BeC	25. Was case referred to medical examiner?				26. Place of Death		10 10 103	20140
ot V	S 0 = 0	70	1 ☑ Yes 2 ☐ No	lospital: 1 🔲 Inpatient	2 ER/Outpatient	3□ DOA Other	4 🗆 Nursing Hor	ne 5 Mesidenc	e 6 □Other (Specif	(y)
			27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Y	28b. Time of Injury	28c. Injury Work	at 2	28d. Describe how i	injury occurred	
sio	Attending r death. sctor: After by the fune	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be				es 2 No			
Division	l or Attendater death	Certification:	4 Homicide determined	28e. Pface of Injury building, etc. (At home, farm, stre Specify) 	et, factory, office	2	28f. Location (Stree City or Town, S	t and Number or Rura Itate)	il Route Number,
	Hospitel or 14 hours afte Funerel Dire tely filled in t		CO. C. W	1-1						
1	Hos 24 ho Fun Fun	ledical	29a. Certifier 1 rtifying Phys (Check only 2 Medical Examinate)	sician: To the best of r	amination and/or inv	occurred at the time estigation, in my opi	e, date and place, a nion, death occurre	and due to the caus and at the time, date	e(s) and manner as si and place, and due to	tated. the cause(s)
	To the Hospitel or Attenwithin 24 hours after deata To the Funeral Director: completely filled in by the	Mec	29b. Signature and title of certifier	and manner state	4.	29c. License			Date signed (Month,	
	⊢ 3 - 3		AN DOOR	6	MI					
	1		30. Name and address of person who co	moleted cause of deal	h (Item 23a) (Type 5	Print)	111		grah 9, Z	004
			100	ON IE 3933	Staling	LONE FI	1:61	Suma	archa, z	71012
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	Priva LL	MI CONT	117/11/11	7-101N) (- 1044
	Registr	ar	MAR 1 7 200	4 Sener	me g	Soorka	/			

			For State	State of Ma	aryland / Depa	artment of H			711111	08521
			Registrar 1. Decedent's Name (First, Middle, La	st)	- Ce	runcate of L	,	2. Date of Death	J. No.L O C	3. Time of Death
	Physici		ETra Ch	arles	Harri.	5		Month 1ARCH	Day Year 9 2004	м
4	/Medic Examir		4a. Facility Name (If not institution, giv	e street and number)			Location of Death	ZARCH	4c. County of Death	5:40P.
			6306 TOONE STREET			BALTIMO	RE CITY			
	Funeral Director	\mathcal{A}	インレーナンノー	M 2□F	(In yrs. last birthday)	If Under 1 Year Months Days	It Under 24 Hrs. Hours Min.	8. Date of Birth Day.	50 Ma	place (State or Foreign intry)
	ow ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	ath with the Marylan 23s or 28s-f show	Director	MD		Balt	imore	<u> </u>	100	Citizen at Market	1 Yes 2 No
	23a or 2		10e. Street and Number	o Stran-	<u></u>	10f. Zip Code	24	100	g. Citizen of What Cou	.ntry r
	ter death	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	Ever in U.S. 13.	Was Decedent of His	spanic Origin? (Spec	cify Yes or No-	14. Race - Amer	
920	ta o	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 N It Yes, Give Year or Dates:		It Yes, specify Cubar 1 ☐ Yes 2 No	Specify:	ican, etc.)	Specify:	lack
5-0036	72 hours "natural",	Completed	15. Decedent's E (Specify only highest gr		(Give	dent's Usual Occupa	luring most of workin	a 16	6b. Kind of Business/Ir	ndustry
2121	within	id m	Elementary/Secondary (0-12)	College (1-4or 5	a life.	DO NOT use retired)	Dolive		Termon	mts to
d 2	Hygie Hygie ther t	ပိ	17. Father's Name (First, Middle, Last)		gye.	18 Mother's Name	(First, Middle, Ma	iden Sumame)	unaum
Maryland	ges 1 and 2 should be filed within to f Health and Mental Hygiene. If item 27 is marked other than or other traumatic svent, Its M.	To Be	Walter T. H	25Tis			Pauli	ve So	ander	
ary	shou and M s mar		19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Street a	nd Number or Rural	Route Number, C	City or Town, State, Zi	p Code)
	of Health a litem 27 lu	-1	outine 14/e	r (Mothe	r) 481	aBeau	FORT A	ve, B	TAO MD	2/2/5
3altimore,	ges 1 t of He if iter or oth		20a. Method of Disposition 3	Removal from State	20b. Place of Dispo cemetery, crea	osition (Name of matory or other place	Da Da	ate 20	c. Location - City or T	own, State
ţi	permit. Pag Department Important: I any injury c		'4 □Donation 5 □ Other (Special		King Me	morialy	Part 3/15	1041	Sultimor	eMD
Bal	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service Lice	There		aygui (" Circles	& Tru	graf Ser	dices 1
			23a. Part1. Enter the disease, or com	plications that caused	the death. Do not en	ter the mode of dying	, such as cardiac or	respiratory arrest	Salton	Approximate
	Physician		shock, or heart failure. List only Immediate Cause (Final		elerotic C	ardioraco	ilan Digo:	200		Interval Between Onset and Death
7	/Medical		disease or condition resulting in death)	ч.	a consequence ot):	atutovasci	TIGE DISE	ase		
	Examiner		Sequentially list conditions.	b						
	pe sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	a consequence of):					
	xecuti and al-tran	хап	that initiated events resulting in death) Last	cDue to (or as a	a consequence of):					
8760,	eath certificate be executed attending physician and for use as the burial-transi	dical	l	d						
9	tificate ig phy as the	ledic								
Вох	th cer lendir r use	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		JEctopic pregnancy			23d. Date of deliv	
O. E	Attending Physician: The law requires that the death certific death. ector: After this certificate has been signed by the attending p ector: After this certificate can be been signed by the attending by the funeral director, page 2 should be detached for use as	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at 9□Unknown		Other (specify)			Month	Day Year
. P.O.	w requires that the de been signed by the should be detached	H.	Part II. Other significant conditions	contributing to death bu	ut not resulting in the u	nderlying cause give	n in Part I.	23e. Did tobac	cco use contribute to	the cause of death?
Division of Vital Records,	quires n sign ald be	d by						1 🗆 Yes	2 □No 3 □ Pro	bably 4 Unknown
000	law rec as bee 2 shou	Completed						24a. Was an	24b. Were auto	opsy tindings available ompletion of cause of
Re	The lav	mo;						autopsy performe 1 Yes 2 5	d? death?	ompletion of cause of
ital	i cian: Th certificate rector, pag	Be C	25. Was case reterred to medical examiner?				26. Place of Death		7.10	
of V	Physic this ce al dire	၉	1 X Yes 2 No	Hospital:			4 Nursing Hom		ce 6X1Other (Speci	NSCENE
o uc	ding P	lon	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	y Year) 28b. Time o Injury	Work	?	3d. Describe how	injury occurred	
isio	death death ctor: /	licat	2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not b	O Dlago of lain	ıry - At home, tarm, sti		es 2 □No	of Location (Street	et and Number or Run	al Route Number
Ω̈́	after after Direct	Certification:	4 Homicide determined	building, etc	(Specify)	oot, radiory, office		City or Town,		2 100.0 . 10.1100.
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical C	29a. Certifier 1 Certifying Pl	nysician: To the best of miner: On the basis of and manner sta	examination and/or in	h occurred at the time vestigation, in my op	e, date and place, as inion, death occurre	nd due to the caus d at the time, date	se(s) and manner as s and place, and due t	stated. o the cause(s)
	To the within 2 To the complet	Med	29b. Signature and title of certifier	and manner sta	190.	29c. License	number	29d	. Date signed (Month,	Dey, Year)
	⊬ ≱ ⊬ 8		hing di	mid			C.M.E.		RCH 10,200	
	N		30. Name and address of person who	completed cause of dr	eath (Item 23a) (Type,				,	
_			LING LI M D				Street. F	Baltimore	e, Marylan	d 21201
	Sta Regista	ate rar	31. Date filed (Month, Day, Year) MAR 1 7 2004	32. Registra	ur's Signature	9 0	,			
	3			The state of the s	For Assess					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death Day Year Month **Physician** endrick-Harch 2004 10 /Medica! 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Bal timore amaritan Hospi If Under 1 Year | If Under 24 Hrs. 6. Sex (ast birthday) Birthplace (State or Foreign Country) **Funeral** SHERY Days Hours 1 □ M 202 Director Usual Residence of Decedent State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f ehov the Medical Examiner must be notified a 1 Nes 2 No Be Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married Married Baltimore, Maryland 21215-0036 1 Yes 2 No 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12015 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be filment of Health and Mental H 19b. Mailing Address (Street and Number injury or other 1 Burial 2 Cremation 3 Removal from State Department of Important: If any Injury or once. □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory are shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** psis /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physiclan/Medical Examiner Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day 4 Pregnant at time of death 5 Other (specify) Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No autopsy performed 1 Yes 2 110 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 4 No 1 Inpatient 2 ER/Outpatient Certification: To 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 2 Natural 5 Pending after death. death. 1 Tyes 2 No investigation 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by To the Hospital within 24 hours a To the Funeral D Medical 1 🗲 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 15309 LOEL RAVEN BLUD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601 Hospital Good Samalita 32. Registrar's Şignature

Registrar

		•	For Amend Item#30 per State	itate of Marylar ivr G829 3/17/	nd / Depa 04 tas <i>Cei</i>	artment of H rtificate of L	ealth and N Death	Mental Hy	giene Reg. No. 200	4 08523
1			Decedent's Name (First, Middle, Last)					2. Date of De Month	ath Day Yea	3. Time of Death
	Physicia /Medic	al	·	Henkel, Jr	•			March 13	3 2004	6:50 P M
è	Examin	er	4a. Facility Name (If not institution, give stre 1414 Front Avenue Host		o r e	Baltimore	County		4c. County of D	
	Funeral		5. Social Security Number 6. Sex		. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da March 3	th 9.	Birthplace (State or Foreign Country) TSDUCTH, PA
	Director		175 12 2627 1 ★ M Usual Residence of Decedent	-2. 02	115.			ratur 3.	7 1921 [110	.GULGI,IA
	nyland show		10a. State 10b. County		ity, Town or Lo					10d. Inside City Limits
	8a-f	Directo	Maryland Baltimore	Bal	ltimore (County 10f. Zip Code			10g. Citizen of What	1 Yes 2 No
	with the or 2	Ö	7837 St Thomas Drive			21236			USA	Obditity:
	ns 23	Funeral		. Was Decedent Ever in t	J.S. 13.	Was Decedent of Hi	spanic Origin? (S	pecify Yes or No	- 14. Race - A	merican Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "netural", or Items 23a or 28a-f show any injury or other traumatic event, the Madical Examiner must be notified at once.	by Fur	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: W		f Yes, specify Cuba 1 ☐ Yes 2 █️No	Specify:	rican, etc.)	Specify:	thite, etc. White
2	72 hou	sted	15, Decedent's Educat (Specify only highest grade of		(Give	dent's Usual Occupa kind of work done of	during most of wor.	king	16b. Kind of Busine	ss/Industry
12	within one.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Engine	DO NOT use retired)		Westinghous	3 ⊆
2	filed v Hygie other 1	e Co	12 17. Father's Name (First, Middle, Last)	6	пенк	**	18. Mother's Nan	ne (First, Middle	, Maiden Sumame)	~
/lan	utd be Mental irked tic ev	To B	Sylvester J Henkel Si	2			Hazel Dor	an		
Maryland 21215-0036	2 sho		19a. Informant's Name/Relationship (Type, Lorraine R Henkel	, Print) (Wife)		•			er, City or Town, Stat faryland 2123	
	1 and Healtl Iem 27		20a. Method of Disposition		Place of Dispo	sition (Name of		Date .	20c. Location - City	
altimore,	Pages lent of nt: If it		1 Burial 2 □ Cremation 3 □ Rem 1 □ Donation 5 □ Other (Specify)	noval from State Par		natory or other place metery Man			Baltimore,Ma	aryland
Balti	permit. Departm Importa any inju	1 1	21. Signalure of Funeral Service Licensee	amore	I 22	2. Name and Address ASSAHN FUNCT 401 Belair T	ss of Facility Cal Home Ir	C Mora	and 21236	
	一二一点		23a. Part1. Enter the disease, or complica shock, or heart failure. List only one	tions that caused the dea						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Smile !	Denn	entin,	Vasan	length	Robernen	Onset and Death
<i>1</i>	/Medical Examiner		resulting in death)	Due to (or as a conse	guence of):	en que	lenie 1	vost	in and	2
Ε.		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	equence of):	1			1, 1	
	ecuted and transit	Examiner	Cause (Disease or injury that initiated events c resulting in death) Last	Instern		enepri	rusul	in 19th	ulling	3910
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9	tificate ig phys as the	ledicai	0							
Вох	th certific fending p or use as	an/IN	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	. If yes, outcome of pregr 1 Live birth 2 Fel	tal death 3[⊒Ectopic pregnancy			23d. Date of Month	delivery Day Year
P.O. E	that the death certiff ed by the attending detached for use as	ysici	1 Yes 2 No	4 Pregnant at time of 9 Unknown	death 5	Other (specify)				
٠ <u>,</u>	res that t signed by be detail	y Ph	Part II. Other significant conditions contri	buting to death but not re	sulting in the u	nderlying cause give	en in Part I.	23e. Did 1	obacco use contribut	te to the cause of death?
ord	v require been sig should b	ted	(onen my 15)	roten Su	nese	- 1000 C	ris 1	1 🗆	Yes 2 No 3	Probably 4 Dunknown
Sec	e la has je 2	Completed by Physician/Me	J.NSO Conon) Worter C.	34 DI	oss Gna	a star	24a. Was auto perfo	psy prior ormed? deat	a autopsy findings available to completion of cause of h?
tal			25. Was case referred to medical				26. Place of Dea	1 ☐ Yes		Yes 2□No
ţ Vi	Physician: r this certifica ral director,	To Be	examiner?	spital: 1 Inpatient 2 (☐ ER/Outpatier	nt 3 DOA Oth	or /		dence 6 Other (5	Specify)
Division of Vital Records,	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely tilled in by the funeral director,		27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Worl	y at k? Yes 2 □ No	28d. Describe	how injury occurred	
Visio	Attending or death. ector: Atter by the fune	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, st			28f. Location (City or To		r Rural Route Number,
Ö	ital or A rs after al Dire	Cert	4 Holmicide	building, etc. (Spec				Only or 10		
	To the Hospital within 24 hours a To the Funeral C completely filled	edicai		cian: To the best of my kr r: On the basis of examin and manner stated.						
	To the To the comple	Me	29b. Signature and title of certifier	10		29c. Licens			29d. Date signed (M	onth, Day, Year)
)	XI		Michall	When.	2	2.0	0276	93	3/15	104
	13,		30. Name and address of person who com							
	C+	ate	Michael A.Hyle 3010 Gi	Lbbons Ave. Ba 32. Regismar's Sign		21214				
	Regist		2000 0 4 2 4	PONA PROMO	11	Brock &				

			1 = For State Registrar	State of Mary	land / Dep	artment of H	leaith and M	Mental Hygid	ene 2004	08524
			Decedent's Name (First, Middle,	Last)		· · · · · ·		2. Date of Death		3. Time of Death
	Physici		Milton	B. Harri	S			March	12 2004	12:15 A ^M
1	/Medic Examir		4a. Facility Name (If not institution,			4b. City, Town, or	Location of Death		4c. County of Deeth	1 1 2 · 1 3 / A
	Exami		8237 Quarterfi	eld Road		Severn			Anne Arun	de l
	Funeral		5. Social Security Number 6		yrs. last birthday	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day, Y		place (State or Foreign
	Director		217-14-0550	1 ∑ M 2□F	80 Yrs.	Months Days	Hours Min.	Dec. 31	1923	NC.
	p		Usual Residence of Decedent							
	how	_	10a. State 10b. County	10	c. City, Town or L	ocation				Od. Inside City Limits
	Ba-f	5	Maryland Anne	Arundel		Severn		······································		1 ☐ Yes 2 ☑ No
	ith th	Director	10e. Street and Number			10f. Zip Code		100	g. Citizen of What Cou	ntry?
	within 72 hours after death with the Maryland ene. than "natural", or Iteme 23e or 28e-f ehow ta Medical Exercitar mast be notified at		8237 Quarterfi	eld Road			21144		USA	
	teme	Funeral	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No- p Rican, etc.)	14. Race - Americ Black, White,	
36	or h	by Fi	1 Never Married 2 Married	If Yes, Give		1 ☐ Yes 2 ☒ No	Specify:		Specify: Wh	ite
8	ural	d b	3 Widowed 4 Divorced	Year or Dates:	1 10 0					
<u>5</u>	"nai	lete	15. Decedent's (Specify only highest		(Give	edent's Usual Occupa e kind of work done o DO NOT use retired	ation furing most of work	king	b. Kind of Business/In	dustry
12	withi ene. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	,,,,,	Truck Dri			Commerc	ial
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an	Mental Merital Mrked o	o Be	Charles F	. Harris			Gracie	,	phries	
<u></u>	2 shoul and Me is mark eumati	ပ္	19a. Informant's Name/Relationship		19b. Mail	ing Address (Street			City or Town, State, Zip	Code)
Maryland 21215-0036	カニトン		Elaine Harris	(spouse)	1					
	s 1 and if Healt item 2 other		20a. Method of Disposition		Ob. Place of Disp	osition (Name of	Mana	Date 16	. VD 21144 c. Location - City or To	own, State
Baltimore,	0 = =		1 🖾 Burial 2 ☐ Cremation 3 3 4 ☐ Donation 5 ☐ Other (Spe	Removal from State	-	en Cemeter			len Burnie	Maxyland
Ħ			21. Signature of Funeral Survice Lice	A Land		2. Name and Addres				
Ba	Departr Departr Imports eny inj		Much (1)	14610, 1	7)				ngs runera na, MD 2112	Home, P.A
	4		23a. Part1. Enter the disease, or constitute. List or	emplications that caused the	death. Do not en					Approximate Interval Between
	Physician		Immediate Cause (Final	nly one cause on each line.		Meito	whin	Puluru	1.0- 40	Interval Between Onset and Death
8	/Medical		disease or condition resulting in death)	Due to (or as a co	nsequence of):	000)	-0100) and cont	
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	es the	by F	Part II. Other significant conditions	s contributing to death but no	t resulting in the u	inderlying cause give	n in Part I.	23e. Did tobac	cco use contribute to the	e cause of death?
D	v require been si should t							1 XVres	2 No 3 Prob	ably 4 □Unknown
S	e law re has be re 2 sho	plet						24a. Was an	24b. Were auto	psy findings available
Vital Records,	The late has page	Completed						autopsy performer	d? death?	npletion of cause of
ita	sician: Th certificate rector, pag	0	25. Was case referred to medical	har and			26. Place of Deat	h Check on on	3 ,0	2010
f V	S 0 0	To B	examiner? 1 ☐ Yes 2 No	Hospital:	2 ER/Outpatie	nt 3 DOA Othe	or: 4 Nursing Ho	ome 5 esidenc	e 6 □Other (Specify	·)
οl	ding Phy I. After thi funeral		27. Manner of D ath	28a. Date of Injury (Month, Day Yee	28b. Time o	of 28c. Injury Work	at	28d. D scribe how	injury occurred	
Ö	Attending r death. ctor: After by the fune	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigat	aon	ni, ary		es 2 □No			
Division	or Attendater deatl	Certification;	3 Suicide 6 Could not 4 Homicide determine		At home, farm, st	reet, factory, office		28f. Location (Stree City or Town, S	et and Number or Rura	l Route Number,
Ö	tel or safter al Dire	Cer		*					,	
	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physician: To the best of my aminer: On the basis of exa and manner stated.	knowledge, deat mination and/or in	h occurred at the tim vestigation, in my op	e, date and place, inion, death occur	and due to the caus red at the time, date	e(s) and manner as st and place, and due to	ated. the cause(s)
	To the within 2 To the complet	Me	29b. Signature and time of certifier	γ		29c. License	number	29d.	Date signed (Month,	Dey, Year)
	. \		IIm	m			7/13	/ n	narch, Su	, beey
	/X,		30 Name and address of person wh	no completed cause of dear	(Item 23a) (Type,	Print)	R	14	(1	11000
	\(\int \) Sta	te.	31. Date filed (Month, Day, Year)	78990 32 Registrar's S	an www.	red 61-en	y Dur	My M	ayland	21001
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State of Maryland / Department of Health and Mental Hygiene 2004 1 - For State Registrat Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Harklercaa **Physician** 535 lari March 2004 /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Bayuiew Medical Center HOPKINS Baltimore N/A 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 M 20XF 65 Yrs 1938 Virginia Director 225-52-6417 May 12, Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-1 show 1 Yes 2 No Maryland Baltimore Dundalk Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 2011 Inverton Road 21222 Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. r than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Ite 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White ð 3 XWidowed 4 ☐ Divorced ted 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Complete Elementary/Secondary (0-12) College (1-4or 5+) Balto. Co. School Bus Driver County Transportation 12 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Charles Hall Jessie Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Carole S. Warble (Daughter) Dundalk, Maryland 21222 8108 Eleanor Terrace 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1∑ Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill Mem. Gdns. 3/20/2004 Middle River, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) injury Signature of Funeral Service Ligensee 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222 23a. Part1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, in the mode of dying, such as cardiac or respiratory arrest, in the mode of dying, such as cardiac or respiratory arrest, in the mode of dying, such as cardiac or respiratory arrest, in the mode of dying, such as cardiac or respiratory arrest, in the mode of dying, such as cardiac or respiratory arrest, in the mode of dying, such as cardiac or respiratory arrest, in the mode of dying, such as cardiac or respiratory arrest, in the mode of dying, such as cardiac or respiratory arrest, in the mode of dying, such as cardiac or respiratory arrest, in the mode of dying, such as cardiac or respiratory arrest, in the mode of dying, such as cardiac or respiratory arrest, in the mode of dying, such as cardiac or respiratory arrest, in the mode of dying, such as cardiac or respiratory arrest, in the mode of dying, such as cardiac or respiratory arrest, and the mode of dying arrest, and the mode of dying arrest or the mode Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** tailure Kespiratory /Medical Due to (or as a consequence of): Examiner cell lung cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Immunosuppression, kidney transplant 1 Yes 2 No 3 Probably 4 Unknown peeu 24b. Were autopsy findings available prior to completion of cause of death? stage renal disease 24a. Was an autopsy perform 2 □ No 1 Yes 1 Yes 2 No fo the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) neral Director: After the filled in by the funeral 28c. Injury at Work? 27 Manner of Death 28h. Time of 28d. Describe how injury occurred Certification: 5 Pending 1 XNatural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier 23009 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, Maryland 21224 4940 Eastern treeman, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 1 7 2004 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

			For	State of Marylan	d / Depa	artment of H	lealth and	Mental Hy	giene	0001	
		•	State Registrar		Ce	rtificate of I	Death		Reg. No.	2004	08526
ï			1. Decedent's Name (First, Middle, Last,)				2. Date of De	ath Day	Yeer ,	3. Time of Death
	Physicia /Medic		Bobby Gene Holbro	ook				No.3	15	200	1 2.35 p. M.
	Examin		4a. Facility Name (If not institution, give	itor -	L 1	4b. City, Town, or	Location of De	eath	4c. (County of Death	
			1/1/21/1	lare 116pm	a	If Under 1 Year	If Under 24 H	frs. 8. Date of Bir	***	0-11	MOYEU
	Funeral		5. Social Security Number 215–82–5704	x 7. Age (In yrs. 3 M 2 □ F 45	last birthday) Yrs.	Months Days		in. June 1	iy, Year)		nplece (State or Foreign untry) yland
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	/land	Ì	10a. State 10b. County	10c. Cit	ty, Town or Lo	ocation					10d. Inside City Limits
	Mar.	ğ	Maryland Baltin	nore	Esse	ex					1 Tes 2 No
	or 28	Director	10e. Street and Number			10f, Zip Code				ten of What Co	
	death with the Maryland ms 23a or 28a-f show	ral	844 Middlesex Roa			21221		10 1/ 1/		ed Stat	
	er de.	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	l.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Origin? an, Mexican, Pu	(Specify Yes or No ierto Rican, etc.)	ļ	 Race - American Black, White 	e, etc.
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3			15. Decedent's Edu	cation	16a. Dece	dent's Usual Occup	ation		16b. Kir	nd of Business/	ndustry
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9		Be (17. Father's Name (First, Middle, Last)				18. Mother's I	Name (First, Middle	. Maiden :	Sumame)	
<u> </u>	should be nd Menta marked imatic e	ဥ	Carl A. Holbrook					e Adams	0.1	T Cara 7	"- O- d- \
Maryland	S is a		19a. Informant's Name/Relationship (T)			ing Address (Street			-		
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Baltimore,	Pages nent of I ant: If its ary or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ I	Removal from State	-	matory or other plac Service Co		/18/2004	TOW	son, Ma	ruland
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687	ficate physis the			u							
Box	nding use a	M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregn		□Ectopic pregnancy	.,		2	23d. Date of deli	
m.	The iaw requires that the death certifica to has been signed by the attending ph tage 2 should be detached for use as th	Physician/Med	in the past 12 months? 1 □ Yes 2 □ No	1☐Live birth 2☐Fet 4☐Pregnant at time of 9☐Unknown		Other (specify)	y —			Month	Day Year
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s,	w requires that been signed to should be deta	by	Part II. Dther significant conditions co	ontributing to death but not re	sulting in the	underlying cause giv	ven in Part I.	1			the cause of death?
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2	after Dire	Certification:	4 Homicide	building, etc. (Spec	ify)			City or 10	wn, State,	,	
	To the Hospitel or Attending F within 24 hours after death. To the Funeral Director: Atter completely filled in by the funer			ysician: To the best of my kn							
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			141100	7/4/		Dog	056	270	5 -	15-	2004
	2		30 Name and address of person the	completed cause of death (Ite	m 23a) (Type	Print)	Sauce	Ivo. Ar	Pari	Himm	2004 e, Hd. 2123
	~	ata	31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature	I WITH WITH	134111	ile UI.		TOTAL	U, MU. alay)
	_ 31	ate	MAR 1 7 2004	Bak	6	/					

Jason Spencer Horich Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 04-075 State of Maryland / Department of Health and Mental Hygien [] 04 - 17781- State Amend Item 26 per ME, G829, 03/17/04dhb Certificate of Death DAP 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MARCH 11, 2004 Physician JASON SPENCER HORICH 2:20 a M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HILL SPRING DRIVE & WEST SEMINARY RD TOWSON BALTIMORE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Birthplace (State or Months | Days | Hours | Min. | OCT - 3, 1975 | MARYLAND Social Security Number 14-13-2850 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1[XM 2□ F Months 28 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location Show 10d. Inside City Limits r 28a-f show BALTIMORE MD OWINGS MILLS 1 ☐ Yes 2 🛣 No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or Itama 23a or tre Medical Executer must be 12750 GREENSPRING AVENUE 21117 USA death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. within 72 hours after 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: <u>م</u> Specify: 3 Widowed 4 Divorced WHITE Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) other than SCREEN WRITER ADVERTISING TV/FILM 4 fited 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) es 1 and 2 should be fil of Health and Mental H If Item 27 Is marked ott or other traumatic even Be CHARLES H. HORICH FRANCES SPENCER VEALE 19a. Informant's Name/Relationship (Type, Print) g Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FRANCES HORICH 12750 GREENSPRING AVE. OWINGS, MILLS 21117 mother 20b. Place of Disposition (Name of 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Ite
any injury or ott 20c. Location - City or Town, State THOMAS EPISC. 1 Burial 2 Cremation 3 Removal from State \$T. 03/15/2004 OWINGS MILLS, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fugeral Service Mcen 22. Name and Address of Facility HENRY W. JENKINS & SONS CO. 16924 YORK RD. MONKTON, MD 21111 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line \(\bar{\chi}_{\text{A}} \) Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and s the burial-transit Due to (or as a consequence of): Physician/Medical as IF FEMALE esn 23c. If yes, outcome of pregnancy
1□Live birth 2 □ Fetal death
4□Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 □ No 24a. Was an certificate has page 2 autopsy performed? Division of Vital Yes 2 □ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Hospital: Other: 4 Nursing Home 5 Residence 325ther (Specify) 1X Yes 2 □ No 1 Inpatient 2 ER/Outpatient 3 DOA Scene 27. Manner of Death 28a. Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending I 24 hours after death. Funaral Diractor: After 1 Natural 5 Pending 104 М investigation 1 🗌 Yes 10 acc Accident erinou 3 Suicide 6 Could not be determined 28e. Plan of Injury 28f. Location (Street and Number or City or Town, State) At home, farm, street, factory, office building, etc. (Specify) To the Hospital within 24 hours a To the Funaral C completely filled in 114 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) OCME MARCH 11,2004 person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 M in sock 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

2004

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036	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artiment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Evarthment and inclined at a 2a.	by Funeral	1 Never Married 2 Married 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Pecedent Ever in U.S. of Forces? Yes 2½ No s, Give or Dates:	If Yes, specify Cuba	lispanic Origin? (Specit an, Mexican, Puerto Ric Specity:	can, etc.)	Black, White,	etc.
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Ba	permii Depar Impor any ir		21. Sign ture of Funeral Service Licensee		Connelly F	ss of Facility funeral Homers ers Point R	e Of Dun	dalk,P.A.	21222
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)	To the within 2 To the complet	Me	29b. Signature and title of certifier A COURT GUEL		29c. Licens	052393	29d.	Date signed (Month,	Day, Year)
	10		0 (150)	cause of death (Item 23a) (Ty	2 /	fan.	- 100 3	11224	
	Sta	ate	31. Date filed (Month, Day, Year)	22. Registrar's Signature	ENT NE	BAMIMORE	and a	-ICCT"	
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A Facility Name (if not institution, give street and number) Ac City, Town, or Location of Death Towson Ac City Town, or Location of Death Towson Ac City Town, or Location Towson Ac City Town or Location Town T	2004 0852			
Second Security Name (if not institution, give street and number) 4c. Co. Towson 4c.	3. Time of Death 3:06 Am. _M			
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Physician /Medical Examiner 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, large, leaving to immediate to make the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, limited to condition resulting in death) Due to (or as a consequence of):	d of Business/Industry Private Co.			
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IF FEMALE: 23c. If yes, outcome of pregnancy 23c. If yes, outcome of pregnancy 23c. If yes, outcome of pregnancy 1	d. Date of delivery Month Day Year			
	contribute to the cause of death?			
	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No			
1 Inpatient 2 ER/Outpatient 3 DOA Other 4 Mursing Home 5 Residence 6 C 27. Manner of Death 28a. Date of Injury (Month, Day Year) Injury Work?				
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29a. Certifier (Check only one)	d manner as stated. ace, and due to the cause(s)			
29b. Signature and title of certifier 29c. License number 29d. Date si 3	igned (Month, Day, Year)			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 d Louk W 7825 York Road Towson MD Z State 31. Date file Month, Pay, Year) 4 32. Registrar's Signature	1204.			

			1 - For State Registrar		Marylar			nt of He	ealth and Death		Reg. No.	2004	085	3.0
Н	Physicia	an	Decedent's Name (First, Mide				_			2. Date of D Month	Day	Year	3. Time of Dea	th
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an	Mental Mental	0 8	Gabriel H. John	son					Elizabe	th C. Si	nith			
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	s t and 2 of Health itam 27 I		Deloris Johnso	n/Wife					Ave. O		ls Mar	land 2	0745	
ore			20a. Method of Disposition	3 □Removal from St		Place of Dispo cemetery, crei	osition (N matory o	ame of other place	· 1	Date		ion - City or To		
Ë	nit. Pages artment of ortent: If it injury or o		`4 □Donation 5 □ Other	(Specify)	For	rt Lind	co1n	Cem.	3/1	2/2004	Brenty	vood, M	aryland	
Baltimore,	permit. Page Department Importent: If eny injury o		21. Signalize of Puneral Service	e Licensee W.M.		1	2. Name 201	and Address Linco Blade	of Facility In, Fune nsburg	ral Home Road Bro	entwood	d Maryl	and 2072	22
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ital	icien: Th certificate rector, pag	ВеС	25. Was case referred to medic examiner?						26. Place of Dea					
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X	To the Hospital or a within 24 hours after To the Funeral Direction completely filled in E	edicai	29a. Certifier 1 Certify (Check only 2 Medical	ring Physicien: To the bas al Examiner: On the bas and manne	is of examina	owledge, deat ation and/or in	h occurre vestigation	d at the time n, in my opi	e, date and place nion, death occu	e, and due to the arred at the time	cause(s) and date and pla	manner as st ce, and due to	ated. the cause(s)	
	To the transfer of the transfer of transfe	ž	29b. Signature and title of certif	ier	//		2	9c. License				gned (Month, I		
	5			Well.	M	D		D46	6741		March	8, 5	1009	
	V		30. Name and address of person Deepa K Sa	n who completed cause chdeva, M	-	m 23a) (Type,	Print)							
	Sta Registr		31. Date filed (Month, Day, Yea	7 2004 32. Re	istrar's Signa	ature	Local	1						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 2006 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Yeer Jackson **Physician** 0545AM March Izabeth 13 2004 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Johns Hopkins Bayurew Medical Center Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Days **Funeral** 1 M 2 X Maryland 87 Oct. 9, 1916 Director 216-01-8095 Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or itams 23a or 28a-f show other traumatic event. It a Medical Examinat must be nytitled at XXYes 2 □ No Baltimore Director N/A Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 21224 6801 Bank Street Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ŽŽNo If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married Specify: White 1 ☐ Yes XX No Baltimore, Maryland 21215-0036 Specify. δ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene important: If Item 27 is marked other than any injury or other trainmaits. College (1-4or 5+) Elementary/Secondary (0-12) Homemaker Own Home 12 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Rebecca Quinn John Burgh, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 46701 Thomas Drive Lexington Park, Maryland 20653 Michael Burgh (Nephew) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 3/17/2004 Baltimore, Maryland Oak Lawn Cemetery 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 21. Signature of Funeral Service Licensee 7922 Wise Avenue Dundalk, Maryland 21222 23a. Part1. Enter the isease, a complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Hy percar bia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner potension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed as the burial-transit Due to (or as a consequence of): attending physicien Division of Vital Records, P.O. Box 68760 Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy Day Month Year ō in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 X No the 9 Unknown 9 Unknowń 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 X No 1 🗌 Yes 3 Probably 4 □Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 🗆 No 1 Tes To the Hospital or Attending Physician: filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after deat To tha Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier RES - 000 March 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eastern Avenue, Baltimore, MI) 21224 4940 Parekh Anand 37. Registrar's Signature 31. Date filed (Month, Day, Year)
MAR 1 7 2004 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 24 Physician GEORGE Kirchheiner 2004 Yarch 15 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Hospital Baltimore Samaritan NIA Good If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** M 2□F 220-03-4720 Director Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d. Inside City Limits "natural", or itams 23a or 28e-f show the Medical Examiner must be notified at 1 Yes 2 No N BALTIMORE by Funeral Director MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21234 U.S. A 3101 HillcresT AVE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: wh. Te Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Importent: If item 27 is marked other than 'na any injury or other traumatic event, the Waulcone. College (1-4or 5+) Elementary/Secondary (0-12) ELECTRICIAN AVER CORP 12th NA 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be (Charles Kirchheiner ANNA UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Balto MO Kirchheiner 3101 21234 Helen hill crest Ave 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 3/19/04 Bal to. MD PALKWOOD cem 22. Name and Address of Facility StellA Funekal HARTICH MILLER STELLA FUNEKAL 7527 harrowd RD. BALLO IN 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Day in the past 12 morths? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ funeral director, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 @Unknown Be Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ NO 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification; To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Injury 1 ANatural 5 Pending hours after death. 1 Yes 2 No investigation 2 Accident Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide the Hospitel within 24 hours To the Funeral 1 crtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and tiple of certifier A. Frafian 15309 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601 Lock Raven Blod Good Samaritan Hospital Abdallah Kafrouni 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Registrar

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	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation					1	0d. Inside C	ity Limits
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38	urs aft	by Funeral	1 XNever Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	10		1 ☐ Yes 2🏋 No	Specify:	White		Specify	Wh	ite	
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and	d be f antal h cad of	To Be	Daniel W. Kolle							Pfeiff		5)		
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ore	es 1 and the state of the state		20a. Method of Disposition 1 ☐ Burial 2 🎖 Cremation 3	Removal from State	20b. Pla	ce of Dispo	sition (Name of matory or other place	ce)	Date	20	c. Location -	City or To	wn, Slate	
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Baltimore, Maryland 21215-0036	permit. Pages 1 and Department of Heal Importent: If Item 2 any injury or other 2005.		21. Signature of Funeral Service Lice	on Ohm	cki		Name and Address 750 Bela:		E. F.		hn Fun le, MD		Home,	P.A.
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	To the Hospitel or Attending Physician: The within 24 hours after death. To the Funerel Diractor: After this certificate his completely filled in by the funeral director, page	edical	(Check only 2 Medical Exa	hysician: To the best of miner: On the basis of and manner sta	examination	on and/or in	vestigation, in my o	pinion, deat	th occurred at	the time, date	se(s) no mar an place, a	nd due to	the cause(s	()
	To the within 2 To the complet	Me	29b. Signature and title of certifier	0 0			29c. Licens				I. Date signed			
	. *) (Cor	Kem))		OCM	IE.		MA	RCH 11,	, 2004		
	10		30. Name and address of person who	completed cause of d	leath (Item 2	23а) (Туре,	Print) 111 Penn	Stran	+ D=1.	timom	Max-	hand	21201	
		100	31. Date filed (Month, Day, Year)	N JE W	ar's Signatu		TT LGIII	PITEE	", DOT	CHIOTE	, Mary	LCILICI	~14U1	
	Sta Registr	-	Address	04 Entra	J. J.	Son	ule							

State of Maryland / Department of Health and Mental Hygiene 08534 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** March 10:30 P M Ernest Knapp 2004 /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Johns Hopkins Bayview Geriatrics Ctr. Baltimore N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** 1 M 2 □ F 74 Director 17, 1929 217-26-2569 Maryland Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location Item 27 is marked other than "naturel", or items 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at XIXYes 2 No Director Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 530 47th Street 21224 United States death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If item 27 is marked other than "naturel", or ite 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖫 No Specify. Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 10 years Supervisor-Green Spring Dairy Dairy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be August Knapp, Sr. Bertha Schultz P 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ldrette Knapp (Wife) 530 47th Street Baltimore, Maryland 21224 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition ö 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If eny injury or once. Hilltop Service Corp. 3/16/2004 Towson, Maryland * 4 □Dopation 5 Other (Specify) 21. Signature de Fisheral Service Conse 22 Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222 Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Congestive heart **Physician** disease or condition resulting in death) 945 /Medical Due to (by as a consequence of): Examiner Myocardial GYC WLEKS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner vointesting The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Be Completed by Physician/Medical as the the attending IF FEMALE use 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ŏ in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed b 23e. Did tobacco use contribute to the cause of death? Acute Renal 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Should Diabetes Mellitus 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed certificate 1 ☐ Yes 2 ☐ No 2 No in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Medical Certification: To 1 Tes 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 Pending investigation 1 Natural 1 Tes 2 No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D43732 March 13, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael Harper 5505 Hopkins Bayuew Circle, Ba Himore MD 21224 Michael 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2004

		1 - State Registrar	State	of Marylar		artment of F		Mental Hyg	iene 20 eg. No.	04 08535
Physic		Decedent's Name (First, Middle, RUT	·	М.		KAT	7	2. Date of Deal Month MARCH		3. Time of Death 8:30 P
/Medi Examir		4a. Facility Name (If not institution, s				4b. City, Town, o	Location of Dea		4c. County o	
Funeral Director		5. Social Security Number 212-14-3793	.Sex 1□M 2□ F	7. Age (In yrs.	last birthday) 82 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		, 1921	9. Birthplace (State or Foreign Country) MD
Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County MD N/A		10c. Cit	ty, Town or Lo	cation IMORE				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
with the 3a or 28a	I Director	10e. Street and Number 2434 W. BELVEDE	RE AVEN	UE	57,2.	10f. Zip Code	21215	1	0g. Citizen of Wh	hal Country?
be filed within 72 hours after death with the Maryland tal Hygiene. Idea Hygiene. Independent than "natural", or Items 23a or 28a-1 show event, the Medical Examinar must be routiled at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ※ Widowed 4 □ Divorced	12. Was De Armed I	cedent Ever in U Forces? 2 X No Bive	1	Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 No	ispanic Origin? (Specify Yes or No- rto Rican, etc.)		- American Indian, , White, etc.
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S E P S	To Be C	17. Father's Name (First, Middle, La JEROME			MITN	ICK	YETTA	me (First, Middle, I	Maiden Sumame,	, KAPLAN
C, NC 1 and 2 s Health ar em 27 is ther trau		19a. Informant's Name/Relationship ALVIN KATZ / S 20a. Method of Disposition			7927 Place of Dispo	STARBURS	ST DRIVE	ural Route Number - BALTIM Date	ORE, MD	
permit. Pages Department of I Important: If it any injury or o		1 X Burial 2 Cremation 3 4 Događon 5 Other (Spe	city) 1	n State	AREI Z	ION CEME Name and Addre	TERY 3/1	5/2004 OL LEVINS	ROSEDA ON & BRO	ALE, MD
Pnysician /Medical Examiner		23a. Part1. Enter the disease, or conshock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	a.	caused the deal each line.	th. Do not ente		g, such as cardia			Approximate Interval Between Opset and Death
cate be executed physician and sthe burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с	o (or as a consec	,					
UNISION OF VITAIL NECOLDS, T.O. BOX OF TO the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes > ☐ No 9 ☐ Unknown	1 ☐ Live	outcome of pregna birth 2 Feta gnant at time of c known	aldeath 3□	Ectopic pregnancy Other (specify)	,		23d. Date Monti	-
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tending P leath. tor: After t	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investiga 3 Suicide 6 Could no	tion	e of Injury onth, Day Year)	28b. Time of Injury	28c. Injun Wor M 1 □	vat /	28d. Describe ho	w injury occurred	d
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the Hos in 24 ho the Fund pletely f	Medical	(Check only one) Medical Ex	aminer: On the	basis of examina pasis of examina oner stated.	ation and/or inv	vestigation, in my o	pinion, death occ		ate and place, an	nd due to the cause(s)
To with con	2	29b. Signature and title of certifier	Z	m)	29c. Licens	3943	21	3/13/	(Month, Day, Year)
		30. Wane and address of person w	ery	70		Print) Enndo	le			
St	ate	31. Date filed (Month, Day, Year)	7 2004	Registrar's Signa	ature	£ .6				

ORIGINAL

		Sta	te of Maryland / I	Department of I Certificate of			iene _{eg. No} 20	04 0	8537
	Physiciar /Medica		Lake			2. Dete of Deet Month March	Day	Year 3.	Time of Death 9:45 PM
	Examine	4a Facility Name (If not institution, give street e Genesis Layhill Nursi:	ng Center		4b. City, Town, or L Silver	Spring		ntgomer	
	Funeral Director	5. Social Security Number 241-30-3178 Usuel Residence of Decedent	7. Age (In yrs. lest bii	rthdey) If Under 1 Year Months Days		(Month, Day,	Year) 4,1925	9. Birthplace Country) North ((Stete or Foreign Carolina
	e Meryland	10a. State 10b. County	10c. City, Tow	n or Location Silver S	pring				Inside City Limits I □ Yes 2 🎇 No
	th with th	10e. Street end Number 13605 North Gate Dr.		10f. Zip Code 2	0906	1	Og. Citizen of V United	Whet Country?	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Meryland Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any Injury or other traumatic event, the Medical Experiment must be notified at other.	1 □ Never Married 2 M Married 1 □ H Y 3 □ Widowed 4 □ Divorced Yes	s Decedent Ever in U,S. ned Forces? Yes 2 ☑ No es, Give ar or Dates:	13. Was Decadent of If Yes, specify Cub	oan, Mexican, Puerto	ecify Yes or No- Rican, etc.)		a - American Ir k, White, etc. Whi	
1215-0	/ithin 72 ho ne. han natur Medical		leted) 16e.	Decedent's Usuel Occu (Give kind of work done life. DO NOT use retire	during most of work ad)	ing	16b. Kind of Bu	siness/Industr	у
and 2	ould be filed w Mental Hygie arked other that attc event, th	12 17. Father's Name (First, Middle, Last) John William	Cockrel1	Homemake	18. Mother's Nam	e (First, Middle, M	Own Maiden Sumam Skin	ө)	
Mary	end 2 should saith end Men n 27 is marke er traumatic	John William 19a. Informant's Name/Relationship (Type, Print Leon H. Lake / Husban	nt) 19b	o. Mailing Address (Stree	t and Number or Rur		, City or Town,	State, Zip Coo	_{de)}
Baltimore, Maryland 21215-0036	Peges 1 e	20e. Method of Disposition 1 ☐ Burial 2 ☑ Cremetion 3 ☐ Remova 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place o cemete.	f Disposition (Neme of ry, cremetory or other pla beake Cremat	nce) Mar		20c. Location - Beltsv:	City or Town,	State
Balt	Department of the perturbation of the perturba	21. Signature of Funeral Service Licensee	M00382	22. Name and Addre Rapp Fune 933 Gist	ess of Fecility ral & Crei Ave., Silv	mation S ver Spri	ervices		
,	Physician	23a. Part1. Enfor the disease, or complications shock, or heart failure. List only one caus	that caused the death. Do e on each line.	not enter the mode of dyi	ing, such as cardiac	or respiratory arre	est,	Apr Inte Ons	proximate erval Between set and Death
	/Medical Examiner	Immediate Cause (Final disease or condition resulting in deeth) e	Stage IV (m	etastatic) (consequence of):	Colon Card	cinoma		1	
•	ing physicien end se state of the second of	P	Due to (or as a o	consequence of):					
O. Box	es that the death certific igned by the ettending p be deteched for use as	Part II. Other significant conditions contributing	g to death but not resulting in	n the underlying cause gi	ven in Part I.	23b. Did to	bacco use con	tribute to the	cause of death?
ds, P.O	signed by	THE CHECK HACTICIONAL	Status		-	1 □ Ye	s 2√No		y 4 ☐ Unknowi
Recor	The law requires that the sete has been signed by the pege 2 should be deteched by Dhyse					perlom	ned?	availab comple of deeth	le prior to tion of cause n?
Vita	Physician: The this certificate and director, per To Re Co.	25. Wes case referred to medical examiner?		C*	26. Place of Deat		θ)		s 2□No
Division of Vital Records,	To the Hospital or Attending Physician: The law within 24 hours elter death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2:	1 183 2 XX 140	Dete of Injury 28b.	Time of 28c. Inju	4 Ki Nursing no	me 5 ☐ Reside 28d. Describe ho			
DIVIS	tal or Attending P rs efter death. al Director: After t led in by the funera	3 Suicide 6 Could not be determined 28e.	Place of Injury - At home, fa building, etc. (Specify)	rm, street, factory, office		28f. Location (Sti City or Town		er or Rural Ro	ute Number,
	To the Hospital or Attending I within 24 hours elfer death. To the Funeral Director: After completely filled in by the funeral Deathfloation	29a. Certifier Check only one) 2 Medical Examiner: On end	To the best of my knowledge the basis of examinetion en d manner steted.	d/or investigation, in my	opinion, death occur	ed et the time, da	ate and place, a	ind due to the	cause(s)
,	Yeithi Tott	29b. Prignature and title of certifier	Tices	29c. Licens	34472	29	ed. Date signed March	(Month, Day,	
	V	30. Name end endress of person who completed Lynne Diggs, M.D.; 1	d cause of death (Item 23e) 0400 Connect:	(Type, Print) icut Ave. #2	202; Kensi	ngton, N	۵D 2089	95	

State Registrar

		For State Registrar		ryland / Der Co	ertificate of L			Reg. No. 20	104	0853
hysici /Medic Examir	al	Dolores E. Aa. Facility Name (If not institution, give	Long		4b. City, Town, or	Location of D	2. Date of D Month March	16, 2004 4c. County	of Deeth	3. Time of Death 6:15 A
ineral rector		213-24-0002	x 7. Age	(In yrs. last birthda 75 Yrs.	Lutherv If Under 1 Year Months Days	II Under 24 l	8. Date of B	Balt		ace (State or Foreig
Sa-f show	Director	Usual Residence of Decedent 10a. State 10b. County Md. Baltimo	ore	10c. City, Town or Luther						d. Inside City Limit
ast be no	rai Dire	300 W. Seminary			10f. Zip Code 2109			10g. Citizen of V	Į	ISA
rail, or items Examiners	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2X N If Yes, Give Year or Dates:	ver in U.S.	I. Was Decedent of Hi If Yes, specify Cuba	spanic Origin; n, Mexican, Pi Specify:	(Specify Yes of Nigerto Rican, etc.)		e-America k, White, e Whit	tc.
ed other then "natural", or items 23a or 28a-1 show event, the Medical Executiver court be notified at	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	ucation de <i>completed)</i> College (1-4or 5-	(Gi	edent's Usual Occupi ve kind of work done of DO NOT use retired Homemaker	luring most of	working	16b. Kind of Bu		ustry
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Important: If eny injury or 2008:		1 🔀 Burial 2 Cremation 3 🗍 '4 Donation 5 Other (Specify, 21. Signature of Funeral Service Licens)	Moreland	Mem. Park 22. Name and Addres Ruck Tows	3-	19-04	Parkvil	ork R	d.
sician edical		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. My	9.		g, such as car	diac or respiratory	1003011		Approximate Interval Between Onset and Death
nysician and he burial-transit au	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	consequence of):					133	
by the attending phy tached for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of 1 □ Live birth 1 4 □ Pregnant at 9 □ Unknown	2 Fetal death	B⊟Ectopic pregnancy □ Other (specify)			23d. Dat	te ol deliver	y Day Year
been signed b should be deta	by	Part II. Other significant conditions co	ontributing to death but		underlying cause give	en in Part I.		tobacco use conti]Yes 2 ☐ No		e cause of death?
ate has page 2	Completed	<u>'</u>					per	opsy formed?		sy findings avaılab ipletion of cause of 2□ No
certificate rector, pag	: To Be	27. Manner of Death	28a. Date of Injur (Month, Day	ot 2 ER/Outpat y 28b. Time Year) Injur	ime of 28c. injury at 28d. Describe how injury occurred					Manor
: After this a funeral di	ation	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	li							
ctor: After th	Certification			ry - At home, larm, . (Specify)	street, lactory, office		28I. Location City or To	(Street and Numb own, State)	er or Rurai	Route Number,
After th uneral	Medical Certification:	2 Accident 3 Suicide 4 Homicide 29a. Certifier 2 Accident 6 Could not be determined	28e. Place of Inju	." (Specify) If my knowledge, de examination and/or	ath occurred at the tir	ie, date and p pinion, death c	City or To	own, State)	ilini a i as ste	itad.

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 08539 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Earlie Franklin Lawson Jr. 2004 March 7:30 /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) Examiner Adventist Health Care Sligo Creek Takoma Park Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplece (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 MM 2□ F Director 579-05-1634 86 01-12-1918 Marshall, Va Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits MD Prince George's Hyattsville 1 Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 1004 Chillum Road 20782 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: Specify þ 3 Midowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)
Real Estate Broker 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) private 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) traumatic Earlie Franklin Lawson Sr. unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 613 Wood Lot Trail Rd Annapolis, MD 21401 Robert Lawson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Slate Peges 1 ment of tpermit. Peges
Department of Importent: if it
eny Injury or o 1 Burial 2 □ Cremation 3 □ Removal from State Fort Lincoln Cemetery 03-18-2004 Brentwood, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatule of Funeral Service Licensee 22. Name and Address of Facility Ft. Lincoln Funeral Home 3401 Bladensburg Rd Brentwood, MD 20722 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line CEREDRO MASCUAR Immediate Cause (Final disease or condition **Physician** resulting in death) /Medical HYPERTENSION. Examiner NEOWTHOU Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? PNEUMONIA, HYPERGLYCEMIA, INTRA CEREBRAL HEMMORHAGE. by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No a. No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification; To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Thomicide within 24 hours a Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier 29c. License number

) 5336 7 29d. Date signed (Month, Day, Year)
MARCH, 12^M, 2004 29b. Signature and title of certifie 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) : WZ GAITHENSIZ VAG, MP: 20878. NWI 32. Redistrar's Signature 31. Date filed (Month) State Registrar

	Dhsissi		For Amend Item #7 State of M.	829 3717762 ,25,27 pee	tificate of Death ME,	2. Date of Death	Day Yeer	08540 3. Time of Death
>	Physici /Medic Examir	al	4a. Facility Name (If not institution, give street and number University of Maryland Medical		4b. City, Town, or Location of Death Baltimerc	03/08	4c. County of Death	22:41 M
	Funeral Director			ge (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth Month: Day, Ye	ar) 9. Birthp	lace (State or Foreign Yland
	e Maryland	Director	10a. State 10b. County MD Baltimore	10c City, Town or Lo	A CONTRACTOR OF THE CONTRACTOR		1	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
	eath with the na 23a or 28	Funeral Dire	10e. Street and Number 6 - 30 FlintShire Ro 11. Marital Status 12. Was Deceden	1. Apt. 20	10f. Zip Code 21237 Was Decertant of Hispanic Origin? (Sr	U	Citizen of What Cour	
900	72 hours after death with the Maryland "natural", or Itema 23a or 28a-f ahow offical Examinar mark be notified at	ρ	1 Never Married 2 Married 1 Yes 2 Married 3 Widowed 4 Drovorced Year or Dates	No	Was Decedent of Hispanic Origin? (Spf Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, Specify: B/	
21215-0036	within lene. then "	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or	(Give	dent's Usual Occupation kind of work done during most of work DO NOT use retired) SE KEEPET	king	. Kind of Business/Ind OUSE Kee	,
Maryland 2	should be filed nd Mental Hygi markad other imatic event, II	To Be C	17. Father's Name (First, Middle, Last) LOWS SC.		18. Mother's Nam Helen	NICHOS	den Sumame)	
	jes 1 and 2: 1 of Health ar if Item 27 is or other trau		19a. Informant's Name/Relationship (Type, Print) 20a. Method of Disposition 1 Ø Burial 2 Ø remation 3 Removal from State	20b. Place of Dispo	natory or other place)	Heights	ty or Town, State, Zip C. T. ROSE Location - City or To	edale, mo
Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Edneral Service Ucenses	MIT. ZIO	Name and Address of Facility OUT P. March F.	5-04 LL	ansdowne edhilton A	2, 1115 21839 288 Baltomi
See	Physician		23a. Part. Enter the disease, or complications that cause shock, or hear failure. List only one cause on each Immediate Cause (Finat disease or condition resulting in death)	line.	er the mode of dying, such as cardiac			Approximate Interval Between Onset and Death
8760,	Medical Examiner physician and the purial-transit	ai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	s a consequence of): Complete	ausing 1055 of armo	PROVED BY MEDICALE		30 minutes
9	iticate g phys as the	edic	d		CERTIFICATION			
P.O. Box	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical		2 Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of delive Month	ory Day Year
	w requires that been signed b should be deta	by	Part II. Other significant conditions contributing to death Morbid obesity; chron			23e. Did tobacc	co use contribute to the	
of Vital Records,	iician: The law r certificate has bu rector, page 2 sh	Completed				24a. Was an autopsy performed 1 Yes 2 D	? prior to condeath?	psy findings available inpletion of cause of
<u> </u>	Physician: this certificated and director, it	To Be	25. Was case referred to medical examiner? 1 A Yes 2 To lea Hospital: 1 Mnpa	ient 2 ER/Outpatier	Other	th <i>(Check only one)</i> ome 5 🗆 Residence	6 Other (Specific	<u></u>
Division of	ling After fune	Certification: T	27. Manner of Death 1 Natural 5 Pending (Month, December 2) Accident investigation	ury 28b. Time o		28d. Describe how in		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
Divi	To the Hospital or Attending within 24 hours after death To the Funeral Director: completely titled in by the incompletely titled in inco		determined 286. Place of I	njury - At home, farm, str stc. (Specify)		City or Town, Si		
	To the Hospital within 24 hours a To the Funeral I completely titled	edical	(Check only one) 2 Medical Examiner: On the basis one)	of examination and/or in	vestigation, in my opinion, death occur	red at the time, date	and place, and due to	the cause(s)
	To the to the comp	W	29b. Signal the and title of certifier Jewah a Tuyla,	MD	29c. License number		Date signed (Month, 53/08/04)	Day, Year)
	19		30. Name and address of person who completed cause of Sennifer Taylor 31. Date filed (Month, Day, Year) 32. Regis		Print) rene St. Baltin	nore, MD	21201	
	St Regist	ate rar	MAR 1 7 2004	ace & A	and in			

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CRG		Dhusisis		1. Decedent's Name (First, Middle	, Last)						2. Date of D		Ye		3. Time of Death	
SO T		Physicia /Medic			DNEY	D.				BERG	MARI	4 1	2	004	1537	М
3	7	Examin	er	4a. Facility Name (If not institution, SINAI HOSPITAL		er)				Location of Dea	h	4c. 0	County of E		M / A	
NOEN		Funeral		5. Social Security Number	6. Sex 7.	Age (In yrs.	last birthday)	If Under	1 Year	MORE If Under 24 Hrs	B. Date of B	irth	9.		N/A ce (State or Fore	eian
Ś		Director		114-09-8184	1 M 2 □ F	84	Yrs.	Months	Days	Hours Min	NOV.8,	1919		Country	" NY	
1	pur	3		Usual Residence of Decedent 10a. State 10b. County		10c Cit	y, Town or Lo	cation						104	L Inside City Lim	nite
7	Manyle	ods l	ō		TIMORE	100.01		SVILL	_					100	I. Inside City Lim 1 ☐ Yes 2 ☑	
E	the	-289- noull	rect	10e. Street and Number	TIMONE		FINL	10f. Zip				10g. Citiz	en of What	Countr		
ONE	th with	23a o	al D	7 SUDBROOK LANE						21208				U.	S.A.	
>	r dea	er mi	ner	11. Marital Status	12. Was Decede Armed Force	int Ever in U	S. 13.	Was Deced	dent of H	ispanic Origin? (S an, Mexican, Puer	Specify Yes or N to Rican, etc.)	0- 1-	4. Race - A Black, V			
Ą,	d 21215-0036 illed within 72 hours after death with the Maryland	"natural", or items 23a or 28e-f show edical Examinar must be notified at	by Funeral Director	1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced	ed 1 Yes 21 If Yes, Give Year or Date	MM	TT	1 🗆 Yes		Specify:	,	!	Specify:	vinto, ott	WHITE	Ξ
	5-0036 72 hours aft	Sal E	ted t	15. Decedent	's Education		16a. Deced	dent's Usua	al Occup	ation		16b. Kin	d of Busine	ess/Indu	strv	
\$	215 ithin 7:	Medi	ple	(Specify only highes Elementary/Secondary (0-12)	t grade completed) College (1-4e	or 5+)	ilite. I	DO NOT us	rk done d se retired	during most of wo	rking				,	
2	24 w	other than	Completed	1]			CLER	<u> </u>	,					AL S	SERVICE	
KNOWN		f Health and Mental Hyg Item 27 is marked othe other treumatic event,	Be o	17. Father's Name (First, Middle, I CHARLES	Last)	1.3	NDENBI	EDC		18. Mother's Na	me (First, M iddl	e, Maiden S	iumame)	- N	,TC	
0	arylan should be	and Mental I is marked o eumatic eve	L _o	19a. Informant's Name/Relationsh	nip (Type, Print)				(Street	and Number or R	ural Route Num	ber. City or	Town, Star		NTE	
V		of Health ar item 27 is other treu		RUTH LINDENBERG	G / WIFE			-		DERE AVE					•	
4	Baltimore,	of He fiterr	. 3	20a. Method of Disposition 1 X Burial 2 ☐ Cremation	3 DRemoval from Sta	1 -	lace of Dispo emetery, crer	sition (Nan	ne of		Date		ation - City			
3	i m	ment tent: i jury o		`4 ☐Donation 5 ☐ Other (Sp	pecify)		TH EL (/2004	LIT	TITZ,	PA		
PArien	Ball Sermit	Department of I- importent: if ite any injury or of		21. Signature of Funeral Service I	Cansee						L LEVIN					
A				23a Part 1 Enter the disease of	complications that cause	sed the deat				ERSTOWN			VILLE	051.00		
	The state of			23a. Part1. Enter the discase of shock, or heart foure. List Immediate Cause (Frial							o or respiratory	u1103t,		0	pproximate hterval Between enset and Death	
		ysician Medical	i	disease or condition/ resulting in death)	a. Due to (or	as a conseq	RATO!	54.	r AV	LURE				//	HR	
	Ex	aminer		Se vientially list conditions	B PER	FOR	ATED	CO	60	~				1	DAY	
	p	sit	iner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	520.110	as a conseq									10 YRS	
	xecut	and al-tran	Examiner	that initiated events resulting in death) Last	c. Due to (or	as a conseq	uence of):	1113	-					_ <	10 YRS	5
	760,	sician e buria	ical E													
	68 tifficat	ig phy as the														
	Box eath cert	tendir or use	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom			∃Ectopic pr	egnancy			23	d. Date of			
	D. E	the at hed fo	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnan 9□Unknow			Other (sp					Month	Da	ay Year	
	P.O.	ed by detac	Ph)	Part II. Other significant condition	ns contributing to deat	h but not res	ulting in the u	nderlvina c	ause give	en in Part I.	23e. Did	tobacco us	e contribut	e to the	cause of death?	1
	ds,	n signi Id be	d by		, and the second			, , ,				Yes 2			iy 4 ∐Unkno	
	C 0	s beel	ompleted								24a. Wa		24b. Were	autopsy	findings availal	ble
	Vital Records, icien: The law requires t	ate ha	mo								auto peri 1 ☐ Yes	ormed?	prior deatl	to comp	letion of cause of	of
	ig in	artifica ictor, (BeC	25. Was case referred to medical examiner?							ath (Check only					
1	of \	this cal dire	7	1 ☐ Yes 2 No 27. Manner of Death	Hospital:		ER/Outpatien			4 Nursing F	lome 5 ☐ Res			Specify)		
6	ding	h. After funer	tion	1 Natural 5 ☐ Pendin	9	Day Year)	28b. Time of Injury	M 2	8c. Injury Work	yat k? Yes 2 □No	28d. Describe	now injury	occurred			
	Division For Attending	ctor:	ifica	3 ☐ Suicide 6 ☐ Could r	not be 28e. Place of	Injury - At h	ome, farm, str			163 2 110	28f. Location	(Street and	Number o	r Rural R	loute Number,	_
	io i	s after at Dire	Certification:	4 Homicide determ	building,	etc. (Specif	v)				City or To	own, State)				
	lospii	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	dical	(Check only 2 Medical	g Physician: To the be Examiner: On the basi	est of my kno	wledge, death	h occurred	at the tin	ne, date and place	e, and due to the	cause(s) a	nd manne	r as state	ed.	
	the	thin 2	Med	one) 29b. Signature and title of certifier	and manner	stated.				e number		29d. Date				
	J J	¥ 1 8				_										,
		10	-	30. Name and address of person	who completed cause of	of death (Iten	23a) (Type.	Print)		-000		MAR	CH	12	2004	
					ATENG	M.	0	Sir	VAI	HOS P	ITAL					
		Sta		31. Date filed (Month, Day, Year)	32 Reg	istrar's Signa	ture	rett s								
		Registr	वा	MAR 17	ZUU4 /48/36	All ship	A	-								

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death MAY Month MOTECH Yeer **Physician** 1123 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BAYLLEW MEDICAL CEMPER BAZTMORE JUHUS HOPKINS If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, 7. Age (In yrs. last birthday) If Under 1 Year Months Days 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Year) 8 220-07-0743 MUCUST 16, 1914 Director Virginia Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or Items 23a or 28a-f shov other traumatic event, the Modical Examinar must be notified at 1 ☐ Yes 200No Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 913 Sue Grove Road 21221 U.S.A. permit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Menial Hyglene. Important: If item 27 is marked other than "natural", or Items 23a any Injury or other traumatic event, the Medical Examine must once. Funeral 12. Was Decedent Ever in U.S. Armed Forces? XXYes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🏋 No Specify: Specify: ۾ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Electrical Technician Aero-Space 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ollie Eilzabeth Oliver David Estes May 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mildred V. May (Wife) 913 Sue Grove Road, Essex, Maryland 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens Of Faith March 17,2004 Baltimore, Maryland 21. Signature of Euneral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 Page Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year 4 Pregnant at time of death 5 Other (specify) the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

N. ASCRUARY NOTZENZ. CAUCER 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 □Unknown . Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform this certificate 1 Yes 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes Certification: To 2 ER/Outpatient 3 DOA Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury Natural 5 Pending 1 Yes 2 No investigation 2 Accident Director: filled in by the 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific RE3-000 MATCH B 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EASTERN MEME, SHOTHORE, MD 21224 31. Date filed (Month, Day, Year)
MAR 1 7 2004 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

				se Type or Prii State of M	nt in Blac aryland /	Department of l	 Ensure All Health and M 	I Copies / lental Hygi	Are Legible.	1
			For State Registrar			Certificate of	Death	Re	g. No.	. 0004
	Physici /Medic		1. Decedent's Name (First, Middle George Louis N					2. Date of Death Month	Day Year	
	Examir	er	1 V	hore 40	. 0 .	- ROSE	or Location of Death		BO T	910m
	Funeral Director		5. Šocial Security Number 216-30-8380 Usuel Residence of Decedent	6. Sex 7. Ag	ge (In yrs. last bi	Yrs. If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Dec. 31	9. Bir C , 1933 M	rthplace (State or Foreign ountry) aryland
	Maryland f ehow	or	10a. State 10b. County Md. Harf	ord	10c. City, Tov	wn or Location Bel Air			-	10d. Inside City Limits 1 ☐ Yes 2€ No
J	with the	Direct	10e. Street and Number 1420 Tayside V	lov		10f. Zip Code	.015		Og. Citizen of What Co	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or iteme 23a or 28a-f ehow any injury or other traumatic event, If a Medical Exacting most be indiffed at ance.	by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Marria 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? ed 1 Tyes 2 1	No 1953	13. Was Decedent of I If Yes, specify Cub			14. Race - Am Black, Whi	erican Indian, te, etc.
2 € C € 215-0036	thin 72 hou e. en "natural Medical E	Completed t	15. Decedent (Specify only highes Elementary/Secondary (0-12)	's Education t grade completed) College (1-4or 5	16a	a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	during most of working	20	6b. Kind of Business child care	
7 7	be filed wit tal Hygiene d other the	Be	17. Father's Name (First, Middle,	Last)		Chief Execut	18. Mother's Name	(First, Middle, M	Kiddie Aca aiden Sumame)	ademy
//၉ィ Maryland	should nd Men marke umatic	2	George William 19a. Informant's Name/Relations!		19	b. Mailing Address (Street	Cecelia (City or Town, State,	Zip Code)
	1 and 2 Health a em 27 Is		Pauline Miller 20a. Method of Disposition	/wife		1420 Tayside of Disposition (Name of		-	. 21015 0c. Location - City or	Town State
Baltimore,	Pages nent of I ant: If ite ury or o		1 Donation 5 ☐ Other (S)		cemete	ery, crematory or other pla athedral Cem	ce)		altimore,	
Balt	permit. Departn Imports any inji		21. Signature of Fune al Service			610 W. M	k Funeral acPhail R	oad, Bel	Bel Air, Air, Md.	
•	Physician /Medical Examiner	ner	23a. Part Enter the disease or shock, or heart failure. List immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, reading to immediate cause. Enter Underlying.	a. Mesent Due to (or as b. Aben 3	a consequence	Fschemo	e bile		st,	Approximate Interval Between Onset and Death
8760,	ate be executed obysician and the burial-transit	dicai Examiner	cause. Enter Underlying Cause (Disease or injury that indiated events resulting in death) Last	cDue to (or as	a consequence	of):				
P.O. Box 687	Physician: The law requires that the death certificate this certificate has been signed by the attending physical director, page 2 should be detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death	n 3 Ectopic pregnancy 5 Other (specify)	/		23d. Date of de Month	livery Day Year
	quires that n signed b ıld be deta	by	Part II. Other significant condition	ns contributing to death b	ut not resulting i	in the underlying cause giv	en in Part I.	23e. Did toba	./	o the cause of death?
Reco	ne faw requir has been si ge 2 should	Completed	Acute Rep	al Fai	lure	500 0- ()	ì	24a. Was an autopsy perform	prior to	utopsy findings available completion of cause of
Vital	sician: The lav certilicate has rector, page 2	o Be Co	Acute Kesii 25. Was case referred to medical examiner? 1 yes 2 no	Hospital:	rollu	reprosto	26. Place of Death	(Check only one	No 1 □ Yes	2 □ No
Division of Vital Records,	Jing After fune	\vdash	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investig	28a, Date of Inju (Month, Da		Time of linjury Wor	4 [(4d) Sing Holi	ne 5 Residen 8d. Describe how	ce 6 Other (Speringury occurred	cify)
Divisi	ospital or Attendi hours after death uneral Director: A ly filled in by the f	Certification:	3 Suicide 6 Could n 4 Homicide determi		ury - At home, fa c. <i>(Specify)</i>	arm, street, factory, office	2	8f. Location (Stre City or Town,	et and Number or Ru State)	ıral Route Number,
6	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical (29a. Certifier 1/1 Certifyin (Check only 2 Medical I	g Physician: To the best Examiner: On the basis of and manner sta	f examination ar	e, death occurred at the tir nd/or investigation, in my o	ne, date and place, a pinion, death occurre	nd due to the cau d at the time, dat	ise(s) and manner as e and place, and due	stated. to the cause(s)
	To the To the Comp	Σ	29b. Signature and title of certifier	iller D.	o.M.	29c. Licens	e number	290	d. Date signed (Monti	h, Day, Year)
	10		30. Name and address of person	who completed cause of d	leath (Item 23a)		rive bo	Himore	= MD 2	1231
	Sta Registr		31. Date filed (Month, Day, Year)	3.7	ar's Signature	Sparke	., , , ,		ــــــــــــــــــــــــــــــــــــــ	, ,

			For	State of Marylan	d / Departme	ent of Health ar	nd Mental Hygier		00011
	1		State Registrar		Certifica	ate of Death	Reg. I	10. 2UU4	00044
	Physicia /Medic	al .	1. Decedent's Name (First, Middle, Las RICHARD As Escillar Name (If not institution, give	WASHINGT		10SLEY ity, Town or Location of	MANCH	Day Year 2004 4c. County of Deat	3. Time of Death
	Examin	er	4a. Facility Name (If not institution, give UNION MEMI			BALTIM	ORE		
er.	Funeral Director		5. Social Security Number 217.09.4625 Usual Residence of Decedent	7. Age (la yrs.	last birthday) If Un Yrs. Monti	der 1 Year If Under 24 ns Days Hours	Add to the Committee of	9. Birt	pplace (State or Foreign INGINIA
	Maryland I-f ahow	tor	10a. State 10b. County	1 11	y, Town or Location	25			10d. Inside City Limits 1 ■Yes 2 □ No
:	after death with the Maryland or Items 23a or 28a-1 ahow miler must be notified at	al Director	10e. Street and Number TVY	AVE.	10f.	Zip Code 21214	10g.	Citizen of What Co	untry?
ρ.	or ite	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		pedent of Hispanic Origin specify Cuban, Mexican, I s 2 No Specify:	n? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Ame Black, White Specify:	
	within 72 hours ane. than "natural", ne Wedical Exe	Completed	15. Decedent's Ed (Specify only highest grade Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	life. DQ NO	Isual Occupation work done during most of Tuse retired) RRIER	of working 16b	Kind of Business/	
/land z	uld be filed Vental Hygi irked other itic avant, ii	To Be Co	17. Father's Name (First, Middle, Last) William	MOSLEY			S Name (First, Middle, Maid BEHY Mos		
, Mar)	and 2 sho salth and 1 n 27 is ma er trauma		19a., Informant's Name/Relationship (7)	S / SON	2101 Cr	ARTERDALE	or Rural Route Number, Cit	y or Town, State, Z TIMOLE, I	Tip Code) MO 21209
Baitimore	Pages 1 ar nent of Hea int: If item iry or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specify	Removal from State	Place of Disposition (semetery, crematory RRISM +	or other place)	3.19.04 DW	Location - City or NGS MILLS	, MACYCAND
Balti	permit. Departminente importe any inju		21. Signature of Funeral Service Licen	7	22. Name	and Address of Facility	VAUGHN C.GR		
5 8 70 8	Physician /Medical		23a. Part1. Enter the disease, or compshock, or heart failure. List only summediate Cause (Final disease or condition resulting in death)	olications that caused the death one cause on each line. a. Due to (or as a consequence)	y Anna	node of dying, such as ca	ardiac or respiratory arrest,	and the second	Approximate Interval Between Onset and Death
	Examiner	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a conseq	OAMDIO	MYOPBTHY			INKMIN
,09/	te be executed ysician and le burial-transit	cal Examiner	cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a conseq	JTM juence of):	BULD			7 DAYS
.O. Box 68	death certifical e attending phy id for use as th	by Physiclan/Medl	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregns 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d	il death 3 □Ectop	ic pregnancy (specify)		23d. Date of del Month	ivery Day Year
٩.	uires that the de i signed by the a Id be detached f		Part II. Other significant conditions o	ontributing to death but not res	sulting in the underlying	ng cause given in Part I.	23e. Did tobacc	\.'	the cause of death?
l Records,	The law requires that the ale has been signed by the page 2 should be detache	Completed			-		24a. Was an autopsy performed	prior to death?	atopsy findings available completion of cause of
Vital	sicien: certific rector,	o Be	25. Was case referred to medical examiner?	Hospital: 1 ⊠ Inpatient 2 □	ISB/Outpatient 35		of Death <i>(Check only one)</i> sing Home 5 \square Residence	C = 000 to 1 (000	
n of	ng Phy iter this	H-	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how in		ciry)
Division of	To the Hospital or Attending Physicien: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		ome, farm, street, far fy)	1 ☐ Yes 2 ☐ Notice	28f. Location (Stree City or Town, S	t and Number or Ru tate)	ural Route Number,
_	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the i	Medical Co	29a. Certifier Check only 2 Medical Example (ne)	ysician: To the best of my kno niner: On the basis of examina and manner stated.	owledge, death occur ation and/or investiga	rred at the time, date and tion, in my opinion, death	place, and due to the cause occurred at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To the within To the comple	We	29b. Signature and title of certifier			29c. License number	29d.	Date signed (Mont	h, Day, Year)
>	X		30. Name and address of person who	completed cause of death (Iter	m 23a) (Type, Print)	H1243894	KWAY BAND	MUH II	1004
			MIBULL PORTOCAL	RERO 201 22. Registrar's Signa	EAST UN	IVENSI IY PAN	KURY BAND	MONE, M	10 21 610
	St Regist	ate	31. Date filed (Month, Day, Year)	A. negistrar's sign	atule				

DHMH 17 Rev 1/2001

		For State Registrar	State of Marylar	•	ment of Ficate of			19. No. 200	
Physicia /Medic Examin	al	1. Decedent's Name (First, Middle, La SAMUEL 4a. Facility Name (If not institution, given HARISOR HOS	Ma			r Location of Dea	MARCH	Day Year 7 200 4c. County of Dec	4 3.024
Funeral Director		5. Social Security Number 6.	Sex 7. Age (In yrs	. last birthday) If	Under 1 Year onths Days	If Under 24 Hr. Hours Min		9. Bi 1962	irthplace (State or Foreig Country) Maryland
e Maryland 3e-f show diffect at	ctor	10a. State 10b. County Maryland	10c. C	ity, Town or Location		altimore		,	10d. Inside City Limits 1 ☐ Yes 2 ☐ No
th with th	Funeral Director	10e. Street and Number 3432 Spelman Road		1	IOf. Zip Code	21225	10	0g. Citîzen of What C U.\$	Country? S.A.
be filed within 72 hours after death with the Maryland Hyglene. Hyglene. dother than "naturel", or items 23a or 28e-f show other than "naturel", or items 23a or 28e-f show event, the Medical Examinar mast be motified at	þ	11. Marital Status 1 🖫 Never Married 2 🗆 Married 3 🗆 Widowed 4 🗀 Divorced	12. Was Decedent Ever in the Armed Forces? 1 ☐ Yes 2 ☑ No if Yes, Give Year or Dates:		Decedent of His, specify Cubi	lispanic Origin? (an, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - Arr Black, Wh Specify:	
d within 72 ho plene. r than "natur the Medical	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)		16a. Decedent (Give kind life. DO	d of work done NOT use retire	during most of wi	orking	16b. Kind of Busines	s/Industry Jkn.
	To Be C	17. Father's Name (First, Middle, Las	B. Moore			18. Mother's Na	ame (First, Middle, A Clar	faiden Sumame) isa Felder	
nd 2 : allth ar 27 is r treu		19a. Informant's Name/Relationship Annette Moore Sister	Type, Print)				Rural Route Number, more, Marylan	City or Town, State, d 21225	Zip Code)
		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 [14 ☐ Donation 5 ☐ Other (Special Content of the Conten	Removal from State	Place of Disposition cometery, cremato	on (Name of ory or other place It. Zion	сө)	Date 2	20c. Location - City o	n , Maryland
permit. Page Depertment of Importent: if any injury or once.		21. Signature of Fundral Service Lice	nsee	22. Na	Estep E	ss of Facility Prothers Fun	eral Home P./ Baltimore, MD	4.) 21217	
Physician /Medical Examiner	ıer	23a. Part1. Enter the disease, or of shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury	plications that caused the dear one cause on each line. a. SEPSIS Due to (or as a conse b. Due to (or as a conse	quence of):		mg, such as cardia		est,	Approximate Interval Between Onset and Death
cate be executed physician and the burial-transit	icai Examin	cause. Criter interlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a conse	quence of):					
Hospitel or Attending Physicien: The law requires that the death certifical 4 hours after death. Funerel Director: After this certificate has been signed by the attending phylical process of the funeral director, page 2 should be detached for use as the funeral director.	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregr 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	tal death 3 □Ect	topic pregnancy her (specify) _	у		23d. Date of di Month	elivery Day Year
quires that n signed b uld be deta	þ	Part II. Other significant conditions	contributing to death but not re	_		ven in Part I.	23e. Did tob	. /	to the cause of death? Probably 4 □Unknow
. The law requir cate has been si page 2 should I	Completed	ALCO HOL	ABUSE				24a. Was as autops perform	24b. Were a prior to death?	autopsy findings available completion of cause of
sicien: Th certificate lirector, pag	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2	☐ ER/Outpatient	3□ DOA O#	100	eath (Check only one	e) ince 6 □Other (Sp	acifu)
r Attending Physer death. rector: After this by the funeral di	Certification; To	27. Manner of Death 1	28a. Date of Injury (Month, Day Year)	ar) 28b. Time of Injury Mork? 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred At home, larm, street, lactory, office 28f. Location (Street and Number or Rur					
To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	edical Cert	29a. Certifier 1 Certifying F	hysicien: To the best of my kr miner: On the basis of examin	nowledge, death oc	curred at the ti	me, date and plac opinion, death occ	ce, and due to the ca	ause(s) and manner a	as stated. ue to the cause(s)
To the within 2 To the comple	Med	29b. Signature and title of certifier	and manner stated.		29c. Licens	se number	29	9d. Date signed (Mor	nth, Day, Year)
´) Sta	ate	30. Name and address of person who GEORG (ACA GEO) 31. Date liled (ALA GA) Year) 2[completed cause of death (lite 2GESCA HARD 32 Registrar's Sign	em 23a) (Type, Prin SOR HOSP nature	TAL 3	001 SOLUT	H HAHOVE	R STREET,	BACTITIONE !

04 - 1711B.K.S Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. UNKNOWN 04-069 State of Maryland / Department of Health and Mental Hygiene, ANTANIA DELICIA 1 - State Registrar Certificate of Death MILLS 2. Date of Death 1, Decedent's Name (First, Middle, Last) Month Day **Physician** Antiona D. Mills 2004 0715 MARCH 8, /Medical 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 2501 TALBOT ROAD BALTIMORE CITY If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
 Waryland **Funeral** 1 MX 2 F Months Days Hours Dec 28 4 988 15 213-23-7170 Director Usual Residence of Decedent the Maryland 10c. City. Town or Location 10a, State 10b. County ir than "natural", or Iteme 23a or 28a-f ehow The Medical Examiner must be notified at 10d Inside City Limits Baltimore N/A 1 ☐ Yes 2 ☐ No Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21216 649 N. Bentlou Street Funerai 12. Was Deceden! Ever in U.S. Armed Forces? 1 ☐ Yes 基☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Rece - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after X Never Married 2 Married Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Student 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry **Baltimore City Schools** Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed v Depertment of Health and Mental Hygies Important: if Item 27 is marked other it eny injury or other traumatic event, IIIs once. 8 18. Mother's Name (First, Middle, Maiden Sumame) Annette MillS 17. Father's Name (First, Middle, Last) Marvin D. Singletary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City of Jawn, State, Zip Code) 649 N. Bentlou Street Baltimore, Maryland 21216 Annette Mills Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Slale Burial 2 ☐ Cremation 3 ☐ Removal from State 03/16/04 Laurel, Maryland Maryland National Memorial Park * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fureral Service Licensee 22. Name and Address of Facility neral Home P.A. 1300 Eutaw Place Baltimore, MD 21217 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Asphyxia and Enysician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, france leading to introduct cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequently of) Examine The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at lime of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Month 5 Other (specify) detached 9□ Unknown 9 M Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were aulopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 1X Yes 2 No To the Hospitel or Attending Physician: the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death Check on one Hospital: 1 InpalienI 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) AT SCENE XYes 2 □ No 2 28b. Time of 28d. Describe how injury occurred Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) Faringry 1 Natural 5 Pending investigation subject assautted 8:00 A M 1 Tes 2 No March B, 2004 2 Accident 6 Could not be 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined filled in by unhown BELLMINE Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MARCH 8, 2004 O.C.M.E Ir 30. Name and address operson who completed cause of death (Item 23a) (Type, Print)

State

Registrar

DHMH 17 Rev 1/2001

ORIGINAL

32 Registrar's Signature

M.D

TashazGireenberg

31. Date filed (MAT) Day Year) 2004

111 Penn Street, Baltimore, Maryland 21201

			State of Maryland / I For Amend Item 19a per Inf., G829, 03/24/04k Registrar 1. Decedent's Name (First, Middle, Last)	Certificate of Death	Reg. No	3. Time of Death
	Physicia /Medic	an	David Nathanie	l Mayers		7, 2004 ^{Year} 8:00 P.M. _M
	Examin	_	4a. Facility Name (If not institution, give street and number) 28 Mercury Ct	4b. City, Town, or Location of Death	kville 4c	: County of Death Baltimore
	uneral Director		5. Social Security Number 6. Sex 1 → 7. Age (In yrs. last bit 216-34-6204 1 → 64	thday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) Dec 18, 19	9. Birthplace (State or Foreign Coufficient) 39 Maryland
Aaryland	stat	o.	Usual Residence of Decedent 10a. State 10b. County 10c. City, Tow Maryland Baltimore	n or Location		10d. Inside City Limits XX 1 ☐ Yes 2 ☐ No
with the A	a or 28a-	Direct	10e. Street and Number 28 Mercury Ct	10f. Zip Code 21234	10g. Ci	tizen of What Country? U.S.A.
1215-0036 within 72 hours after death with the Maryland	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show styl righty or other traumatic svant, the Medical Examination that he notified at ance. 2005e.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Morried 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ Morried 15 Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black
21215-0036 ad within 72 hours aft	iene. than "natur the Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done during most of wor life. DO NOT use retired) Forklift Operator	king 16b. K	(ind of Business/Industry National Gypsum Co.
Maryland 2 and 2 should be filed	lental Hyg ked other ic svsnt, l	To Be C	17. Father's Name (First, Middle, Last) Romeo Lee Mayers	18. Mother's Nar	ne (First, Middle, Maider Leola	n Sumame) Mayers
Mary ind 2 shou	alth and M 27 is mai er traumai		19a. Informant's Name/Relationship (Type, Print) Anna L. Jackson Daughter Friend	o. Mailing Address (Street and Number or Ru 28 Mercury Ct Parkville, M		or Town, State, Zip Code)
Baltimore,	nent of Hei int: If item iry or othe		20a. Method of Disposition 1	of Disposition (Name of try, crematory or other place) Mt. Zion	03/12/04 20c. L	ocation - City or Town, State Landsdown , Maryland
Balti.	Departm Imports sny inju		21. Signatur of Funeral Service Livensee	22. Name and Address of Facility Estep Brothers Fur 1300 Eutaw Place	Baltimore, MD 2	1217
,	ysician		23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition a	not enter the mode of dying such as cardiac	c or respiratory arrest,	Approximate Interval Between Onset and Death
	Medical aminer	1	Surface this list conditions b.			,
8760, cate be executed	physicien and the burial-transit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence c.			
.O. Box 68 the death certificat	by the attending phy tached for use as the	Physician/Medle	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	n 3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
ds, P.	peng pe de	by	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.	23e. Did tobacco 1 ☐ Yes 2	use contribute to the cause of death?
I Records, P The law requires that	ate has been si page 2 should	Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 Mo
of Vital Physician: I	certificate rector, pag	Be	25. Was case referred to medical examiner?	Other	ath (Check only one)	- Tou (a)
P. S.	h. After this funeral di	tlon: To	27. Manner of Death 1 Phatural 5 Pending (Month, Day Year) 28b.	utpatient 3 □ DOA	lome 5 Residence 28d. Describe how inju	
Division I or Attending	within 24 hours after death. To the Funeral Director: A completely filled in by the form	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, for building, etc. (Specify)	arm, street, factory, office	28f. Location (Street a City or Town, Stat	nd Number or Rural Route Number, le)
Di To the Hospital or	within 24 hours after To the Funeral Direct completely filled in by	edical C	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge 2 Medical Examiner: On the basis of examination a and manner stated.	ge, death occurred at the time, date and place nd/or investigation, in my opinion, death occu	a, and due to the cause(s	s) and manner as stated. nd place, and due to the cause(s)
To the	within To the comple	Med	29b. Signature and title of certifier	29c. License number	29d. Da	ate signed (Month, Day, Year)
	5		30. Name and address of person who completed cause of death (Item 23a)	(Type, Print)		to Med 21239
	St	ate	31. Date fill Aprin Par Year 04 32. Registrar's Signature	backs	our isel	TO IND LIES

State of Maryland / Department of Health and Mental Hygiene, 1 - State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month MARCH **Physician** 12, 2004 OR 11:25 A^M /Medical 4c. County of Death 4e. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner BALTIMORE CITY 1507 NORTH BRADFORD AVENUE If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Birthplace (State or Foreign
 Country) 5. Social Security Number 7. Age (In yrs. last birthday)
Yrs. 6. Sex **Funeral** 1 M 2 F 7-38-091 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County or 28a-f ahow r than "natural", or items 23a or 28a-f ahov the Wedical Examiner must be notified at Yes 2□No Director more 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2121 SA 50 items 23a Completed by Funeral death 1 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Yes 2 No f Yes, Give Year or Dates: Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ 40 Baltimore, Maryland 21215-0036 Specify 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) is marked other (First, Middle, Last) Mother's Name (First, Middle, Maiden Be 19b. Mailing Address (Street and Number or Rural Route Number, item 27 i Place of Disposition cemetery, crematory 20a Method of Disposition permit. Pages Department of Important: If it any injury or o 1 Surial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 122. Name and 21. Signature of Funeral Service Liçense Load. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one cause on each line. such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) **Physician** a HYPERTENSIVE ATHEROSCIEROTIC CARDIOVASCULAR DISEASE /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of): Box 68760, attending physicien Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No o 9 Unknown Division of Vital Records, P. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 ₺Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1

Yes 2 □ No 24a. Was an autopsy performed? certificate 1 XYes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? ATSCENE Other: 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. tnjury at Work? 28d. Describe how injury occurred After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident filled in by the Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after To the Hospital within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MARCH 13, 2004 O.C.M.E 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , MD RUBIO ANA 111 Penn Street, Baltimore, Maryland 21201 31 Date filed (Month, Day, Year) MAR 1 7 2004 32. Registrar's Signature State THE PARTY Registrar

State of Maryland / Department of Health and Mental Hygiene 2 08549 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 1130 AM Betty Anne Porter orto 14 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Genera Baltimore land -itu | Tunder 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) | June 6, 1930 5. Social Security Number 7. Age (In vrs last birthday) 6. Sex Birthplace (Stete or Foreign Country) **Funeral** 1 M 2CXF 212-28-9771 73 Director Maryland Usuat Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits or 28a-f show item 27 is marked other than "natural", or Itama 23s or 28s-1 show other traumatic event, the Medical Examinar must be notified at 1 Yes XXNo Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2026 Rocky Point Road 21221 U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black White etc. 1 ☐ Never Married 2X Married 1 ☐ Yes 2 X No If Yes, Give Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☒ No à Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Be Robert Gay Marie Eichoff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Porter (Husband) 2026 Rocky Point Road, Baltimore, Maryland 21221 Baltimore, 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory, Inc. 3/15/2004 Baltimore, Mayrland 22. Name and Address of Facility
Bruzdzinski Funeral Home, P.A. 21. Signature of Funeral Service Licensee 1407 Old Eastern Avenue, Essex, Maryland 2122 23a. Part 1 Ther the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Schemi 010 m /Medical Due to (or as a consequence of): Examiner tag Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of Examiner The law requires that the death certificate be executed physicien and s the burial-trans resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4 Pregnant at time of death signed by the al 5 Other (specify) Ö 9 Unknown 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s certificate has autopsy performed 2□ No Vital 1 Yes 2000 1 Yes Be funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 Impatient 2 ER/Outpatient 3 DOA of After this Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Division or Attending 1 Matural Injury 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospilal 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29d. Date signed (Month, Dey, Year) 29b. Signature/and title of certifier 29c. License number 10 NAPN address of person who completed cause of death (Item 23a) (Type, Print) hehai an 3 6 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 7 2004

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			Registrar			Cer	tificate of	Death		Reg. No.	2004	08550
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	Funeral		Social Security Number 6. Security Number			st birthday)	If Under 1 Yea Months Days			th V Year)	9. Birth	plece (State or Foreign
	Director		Usual Residence of Decedent	⊔M 21 3 0 F	85	Yrs.	Working Day.	Tiodis William	10 16			h Carolina
ylan	how		10a. State 10b. County		10c. City,	Town or Loc	ation					10d. Inside City Limits
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death with the Maryland	piene in then "naturel", or Items 23e or 28e-f show Its Medical Examinet must be natified at	Funeral Director	10e. Street and Number				10f. Zip Code			10g. Citi	izen of What Cou	intry?
ath v	8 23 nust	rai	110 Old Maple Cou			140.14	212				.S.A.	
er de	Item	nue	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent E Armed Forces?		. 13. W	Yes, specify Cu	Hispanic Origin? (S ban, Mexican, Puer	to Rican, etc.)		14. Race - Amer Black, White	
hours aff	7, 0	by	3. Widowed 4 Divorced	1 □ Yes 2 ☑ ▼ If Yes, Give Year or Dates:		1	□Yes 2 √ M	o Specify:			Specify:	nite
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Baltimore	Department of H Important: If Ite eny injury or ot once.		¥EBurial 2 ☐ Cremation 3 ☐		cer	metery, crem	atory or other p				•	
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DOX	for us	ian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 Fetal	death 3□	Ectopic pregnan	су		1	23d. Date of deline Month	very Day Year
કુ	the	ysic	1 ☐ Yes 2 Ø No 9 ☐ Unknown	4□Pregnant at 9□Unknown	ume or dea	atri 5	Other (specify)		***************************************			
r, ja	ed by detac	/Ph	Part II. Other significant conditions of	ontributing to death bu	ut not resul	ting in the un	derlying cause o	iven in Part I.	23e. Did to	obacco u	ise contribute to	the cause of death?
VITAL MECOPOS, sicien: The law requires t	sign Id be	d by	77						101	Yes 2	XNo 3□Pro	bably 4 Unknown
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ysici	direc	To B	examiner?	Hospital: 1 Inpatie	nt 2 E	R/Outpatient	3□ DOA C	net.	lome 5 Resid		6 □Other (Spec	ify)
of Phy	ter th		27. Manner of Death	28a. Date of Injur (Month, Day	y Year)	28b. Time of Injury	28c. In		28d. Describe h			
DIVISION I or Attending	oath. or: Af	atic	1 Natural 5 Pending 2 Accident investigation		,	,,		☐Yes 2☐No				
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Hosp	within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, i	Medical	29a. Certifier to Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best on niner: On the basis of and manner sta	examination	rledge, death on and/or inv	occurred at the estigation, in my	time, date and place opinion, death occi	e, and due to the urred at the time.	cause(s) date and	and manner as I place, and due	stated. to the cause(s)
To th	withir To th comp	Me	29b. Signature and title of certifier	, .				nse number		29 d . Dat	te signed (Month	, Day, Year)
•	3		1/ In Par	shall			D4	000 8		3	11210	4
	6		30. Name and address of person who					-				
			JIM PARSHA		05	FRAN	KLIN	SQUARE	PR., B	AL.	TIMOF	LE, MD.
	Sta		31. Date filed (Month, Day, Year) MAR 1 7 2004	32. Registra	ar's Signay	9° 1	southet					,

1. December Part Pa		_	1 - State Registrar		aryland		artment rtificate				-	g. No. 2	200	
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The control of the co	28a-f show	ector	10a. State 10b. County Maryland Montgom	ery	10c. City	, Town or Lo	Po		ac		10	n Citizer	n of What C	1 □ Yes 2 No
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Pittman Rose Coates	e. "natural", o Medical Exal.	þ	15. Decedent's Edu (Specify only highest grad	Year or Dates:	1942-	16a. Dece (Give life.	dent's Usua kind of wor DO NOT us	l Occupa k done d e retired)	tion	of working	g 1	6b. Kind	of Business	/industry
Trene Dawson / Daughter 14334 Chesterfield Rd., Rockville, MD 20853 20s. Method of Disposition Date D		Be	11 17. Father's Name (First, Middle, Last)			Trucl	k Driv	rer			(First, Middle, M	laiden Su	тате)	Distributo
23a. Part. Erief the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate mode, or horse flailure. List only one cause on each line.	Health a		Irene Dawson / Dar 20a. Method of Disposition	ughter	20b. Pla	143 ace of Dispo	334 Ch	este	erfiel	d Rd	Rock	vill	e, MD	20853
23a. Part : Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Interval Between Onset and Death Pew Shock, or heart failure. List only one cause on each line. 23b. Part : Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Interval Between Onset and Death Pew Day's 25b. Control of the disease or condition resulting in death) I and the death of the disease or condition resulting in death) I and the death of the disease or condition or sulting in death) Last 25c. United the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Interval Between Onset and Death Pew Day's 25c. United the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Interval Between Onset and Death Pew Day's 25c. United the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Interval Between Onset and Death Pew Day's 25c. United the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Interval Between Onset and Death Pew Day's 25d. Date of delivery. In the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Interval Between Onset and Death Pew Day's 25d. Date of delivery. In the death of the	Department of Important: If eny injury or once.		*4 □ Donation = 5 □ Other (Specify) 21. Signature of Funeral Service Incens	ge A	Che	sapeal	ke Cre	emato d Addres uner	ory 2	004 d Cr	emation	Serv	ices	
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29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	fter this	To B	examiner? 1 ☐ Yes 2 🏋 No 27. Manner of Death 1 🛣 Natural 5 ☐ Pending	28a. Date of Inju	y	28b. Time of	28	Bc. Injury Work	r: 4 🗆 Nurs at ?	ing Home	e 5 Resider	nce 6		cify)
	nours after de		4 ☐ Homicide determined 29a. Certifier 11 ☐ Certifying Phy	building, et	of my know	eledge, deatl	occurred a	at the time	e, date and	place, an	City or Town,	State)	d manner as	s stated.
	within 24 h To the Fur completely	Medica	(Check only 2 Medicel Exami	ner: On the basis of and manner sta	examinati	on and/or in	vestigation,	in my op License	number	occurred	d at the time, da	te and pla	igned (Mont	h, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) 8:07A **Physician** NELSON 10 /Medical Facility Name (If not institution, give street and number) 4c. County of Deeth Examiner 6600 RIDGE ROAD TIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Min. Month, Day 5. Sociel Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 213.07.3122 VIRGINIA Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at BACTIMORE 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? OLIVER U.S.A or itame 23a Completed by Funeral permit. Pages 1 and 2 should be filed within 72 hours after dea. Department of Health and Mental Hygiene. Important: if item 27 ie marked other than "naturel" or insert in the page of th 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 W No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian Black, White, etc. 1 Newer Married 2 Married BLACK 1 Yes 2 No 3 1 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation. 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ABORER 17. Father's Name (First, Middle, La 18. Mother's Name (First, Middle, Maiden Surname) Be LOUVENIA DAUCHTER 15 TOUP TREE COURT ESSEY, MD 2 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 315.04 ARBUTUS MARYLAND ARBUTUS CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility VINCTHIN C. GREENE TUNCENCHIM 405 YORK ROAD BACTIMOLE. MARYLAND 21212 21. Signature of Funeral Service Lice 23a. Pert1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician HYPOXIA resulting in death) Hows /Medical Due to (or as a consequence of): Examiner HEART GALLURE ONGESTIVE Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Die to (or as a consequence of) Examiner the attending physician and hed for use as the burial-transit certificate be executed Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.O. ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ BRICHY DISCASE 1 🗌 Yes 2 → No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? Division of Vital 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Aurising Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death. To the Funeral Director: After 1 -Natural 5 Pending 1 Tes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Thomicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 03/11/04 D55306 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DENNIS . H. ODIE SUITE 203 ROSSVICTE PROFF CTR 1732 PART RD BART MD 2123 31. Date filed (Manyto-Pay, Year) 32 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Maryl			t of H	ealth a		ntal Hy	giene	2004	08553
7 3		М	Decedent's Name (First, Middle, Last)						2.	Date of De Month		Year	3. Time of Death
a) _{per}	Physici /Medic		Rodney S. Purner,	Jr.					Ma	rch	12	2004	10:46A M
	Examir		4a. Fecility Name (If not institution, give si	treet and number)				Location of	f Death			ounty of Death	i
t			Abbey Manor 5. Social Security Number 6. Sex	7 Age /In	yrs. last birthday,		ton 1 Year	If Under 2	24 Hrs. g	Date of Bir	th	Cecil	place (State or Foreign
В	Funeral Director		215-30-1462	M 2□ F	71 Yrs.	Months	Days	Hours	Min.	(Month, Da	y, Year)	32 Ma	place (State or Foreign intry) TULand
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	ehov	2	10a. State 10b. County		. City, Town or L	ocation							10d. Inside City Limits 1 ☐ Yes 2 🕱 No
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	dealt	Funeral		Was Decedent Ever i Armed Forces?	in U.S. 13.	Was Deced		spanic Orig	gin? (Specify	y Yes or No		I. Race - Amer Black, White	
9	or ite	y Fu	1 Never Married 2 Married	1 ☐ Yes 2 No		1 ☐ Yes			, r deno mo	an, ott.)		Specify:	white
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or iteme 23e or 28e-f ehow he Madigal Exercites must be notified at	ed by	3 Widowed 4 □ Divorced 15. Decedent's Educ	Year or Dates:	162 Doco	edent's Usua						of Business/Ir	
5	n "na	Completed	(Specify only highest grade	completed)	(Give	kind of wor DO NOT us	k done d se retired	during most	of working		100. Kind) OI DUSINESS/II	loustry
	giene giene ar tha	Com	Elementary/Secondary (0-12)	Cotlege (1-4or 5+)	Asa	sembly	Liv	re Wor	iker		Au	to MFG.	•
Maryland	lid be filed within 72 hours after death with the Marylan lental Hygiene. *kad othar than "natural", or fleme 23s or 28s-1 ehow the othar than "natural", or fleme 23s or 28s-1 ehow to event, the Madical Expresser naturals.	Be	17. Father's Name (First, Middle, Last) Rodney S. Purner						r's Name (F				
<u> </u>	i Men narka natic	2		8.4			/m:		sephin			ley	
<u>a</u>	s 1 and 2 should f Health and Mer flem 27 ie marks other treumatic		19a. Informant's Name/Relationship (Typ Janice Frazer/ Dau			-						Town, State, Zi ty , MD	
ē,	f Heal		20a. Method of Disposition	20	b. Place of Dispo	osition (Nan	ne of		Date			ation - City or T	
Ë	Peges nent of ent: If it ury or o		1 Ø Burial 2 ☐ Cremation 3 ☐ Re 1 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Bethel	-		· 1	larch	17. 2	004 C	he sane o	ike City.MD
Baltimore,	permit. Peges Department of Importent: If it any injury or o		21. Signature of Funeral Service License		2	2. Name an	d Addres	s of Facility	R.T.	Foard	Fune	ral Hon	ne, P.A.
	20 E # 9		Kichard T.	Good.	u	111 5	20	ieen S	reez	, Kis	ing S	un, MD	21911
			23a. Partil. Enter the disease, or complic shock, or heart failure. List only on	e causeyon each line.					cardiac or re	espiratory a	rrest,		Approximate Interval Between Onset and Death
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н	Examiner		1.						no NH	lay i)(SE/	75G	1 YEMES
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	n certi	Z/M	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pre		⊒Ectopic pr					23	d. Date of deliv	ery
Box	deatl	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 ☐ F 4 Pregnant at time of 9 Unknown		Other (sp.						Month	Day Year
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ds,	Physician: The law requires that the death certifica this certificate has been signed by the attending phral director, page 2 should be detached for use as the	by	Part II. Other significant conditions conf	induting to death but not	resulting in the t	indenying ca	ause give	en in Pan I.			Yes 2□		he cause of death? bably 4 Unknown
000	w requ	letec								24a. Was			opsy findings available
Re	The law le has age 2 :	Completed								autoperfo	osy ormed?	prior to co death?	impletion of cause of
Division of Vital Records,	ysiclan: The is certificate had director, page	0	25. Was case referred to medical					26. Place	of Death (C	1 ☐ Yes		1 🗆 Yes	ZIEPNO
>	Physicl this ce al direc	To B	examiner? 1 ☐ Yes 2 ☑ No	ospital: 1 Inpatient	2 ER/Outpatie	nt 3 DO	A Othe					Sother (Speci	M) LIVING
D C	fe		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Yea	r) 28b. Time o		8c. Injury Work	at c?	280	l. Describe l	how injury	occurred	
Sic	Attending or death. ctor: After by the funer	Certification:	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - A	At home, farm, st	M reet_factory		Yes 2□N	_	Location (Street and	Number or Rus	al Route Number,
<u>≥</u>	after after Dire	ertii	4 Homicide determined	building, etc. (Sp	ecity)	root, ractory	, 0///00			City or To		14077007 07 17107	arriodic riambor,
	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu		29a. Certifier 1 Cartifying Phys	ician: To the best of my er: On the basis of exam	knowledge, deat	th occurred a	at the tim	ne, date and	d place, and	due to the	cause(s) ar	nd manner as s	stated.
	the H in 24 the Fi	fedical	oney	and manner stated.	mination and/or in				n occurred a				
	with To Conf	Σ	29b. Signature and title of certifier	1.				number 74	62			signed (Month,	
	01		30. Name and address of person who cor		(ltam 22a) /T			17			7 -	15-0	
	1		Rolando Najera, M	D 138 Cath	edral S	t., El	ktor	ı, MD	21921				
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	Registi	ar	MAR 1 7 200	14 Dation	M. D	10000	•						

			For	State of Ma						lental Hy	giene	0.01	00000
_			1 - For State Registrar AMEND ITEM #5		9 3/22/04	Gertific	ate of I	Death		2. Date of De		004	08554
п	Physicia		1. Decedent's Name (First, Middle, Las Elenora Elizabeth							Month March	Day	Year 004	3. Time of Death 17:14 p M
Ŷ.	/Medic Examin		4a. Facility Name (If not institution, give	·			City, Town, or	Location of	of Death	riar Cir		ounty of Death	<u> </u>
			Johns Hopkins Bay				Baltin		04 Hea	T		1/A	
á	Funeral Director		5. Social Security Number 6. Se 11 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	714 000	e (In yrs. last bii 88	Yrs. Mon	nder 1 Year ths Days	If Under Hours	Min.	8 Date of Birt (Month, Da July 8	n y, Year) , 1915	Cou	place (State or Foreign ntry) Yland
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	m or Location							10d. Inside City Limits
	Maryl -f sho lied a	tor	Maryland Baltimo	re	Dund	alk							1 ☐ Yes 2 1 No
	th the or 28a g.noti	Director	10e. Street and Number			101	. Zip Code				10g. Citizer	of What Cou	ntry?
	ath wi	ral	7826 Kavanagh Roa				2122					d Stat	
	iter de	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Armed Forces? 1 Yes 2		13. Was D If Yes,	ecedent of H specify Cuba	ispanic Ori in, Mexicar	igin? (Spe n, Puerto	ecify Yes or No- Rican, etc.)	- 14.	Race - America Black, White,	
21215-0036	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artiment of Health and Mental Hyglene. ortant: If item 27 is marked other than "natural", or itema 23a or 28a-f show injury or other traumatic event, the Mcg cal Examine must be notified at injury or other traumatic event, the Mcg cal Examine must be notified at 8.		3 Midowed 4 Divorced	If Yes, Give Year or Dates:	10	1 🗆 Ye	s 20 No	Specify:			Sp	pecify: Wh	ite
5-0	72 hc natur	Completed by	15. Decedent's Ed (Specify only highest grad		16a.	Decedent's	f work done o	during mos	t of worki	ing	16b. Kind	of Business/In	dustry
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	il Hygid other	a)	17. Father's Name (First, Middle, Last)		11.	omeman.	CI	18. Mothe	er's Name	(First, Middle,			
ylar	should be nd Mental marked c	To B	John H. Bietsch					Hele	en Sl	immey			
Maryland	12 sho		19a. Informant's Name/Relationship (7							al Route Numbe			
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Baltimore,	Pages nent of int: If it		1 ☑ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Docation 5 ☐ Other (Specify		~> .	awn Ce		· 1	1/16/	2004	Bal+i	more	Maryland
alti	permit. Pages Department of Important: If i any injury or a		21. Signature of Prineral Schripping		1/1/	22. Nam	e and Addres	s of Facilit	tv	ome of		70.0	-0.000-10.000
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			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final	one cause on each li	NΘ.		•						Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a Due to (or as	a consequence	of):	njoco	nde	للعا	infar	ction	ر	
П	Examiner		Sequentially list conditions	b									
	bed sit	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	à consequence	oly.							
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89 x	that the death certifica ed by the attending ph detached for use as th	Med	IF FEMALE:		,		7					The state of the s	
Вох	attend for us	Physiclan/M	in the past 12 months?	23c. If yes, outcome 1□Live birth 4□Pregnant at	2 Fetal death	3 □Ectop	ic pregnancy				23d.	. Date of delive Month	ery Day Year
o.	the de	hysic	1 Yes 2 No 9 Unknown	9□ Unknown	time of double	3 🗆 0 1110	(3000.19)						
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tal	ician: Th certificate rector, pag	0	25. Was case referred to medical					26 Place	of Death	1 ☐ Yes	22 No	1 🗌 Yes	2□ No
of Vi	5 E	ToB	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatie	ent 2 ER/Ou	utpatient 3	DOA Othe			me 5 Resid		Other (Specif	y)
0 0	ding Ph I. After th funeral		27. Mann of Death 1 Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry 28b. 1	Time of Injury	28c. Injury Work	at k?		28d. Describe h			
Division	or Attending after death. Director: After in by the fune	ficat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Inj	urv - At home, fa	M arm. street fa		Yes 2 □	-	28f. Location (S	Street and N	umber or Rum	il Route Number.
Ο̈́	after after I Dire	Certification:	4 Homicide determined		c. (Specify)	arri, stroot, ra	olory, ollico			City or Tow		311301 01 1 1310	
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical ((Check only 2 Medical Exam	vsician: To the best iner: On the basis o	f examination ar	e, death occu	rred at the tin	ne, date an pinion, dea	d place, a	and due to the o	cause(s) and date and pla	d manner as s	tated. o the cause(s)
	To the I within 2. To the I complet	Med	one) 29b. Signature and title of certifier	and manner st			29c. License	number			29d. Date si	igned (Month,	Day, Year)
	⊢ s ⊢ ŏ		Ronald a	Harras	p MC	>	D- 7	209	17		3	15/64	4
	15	- Ä	30. Name and address of person who o	ompleted cause of c	leath (Item 23a)	(Type, Print)		2 14		. 11	1 2	222	
	1		S76 Mesw 31, Date filed (Month, Day, Year)	13 Paniete	ar's Signature	なおい	+ 12	ueti	mo	ie, mo	x. 4	442	
	Sta Registr		31. Date filed (MONIN, Day, 1647)	A Pagisti	A.	A sack	1						

		•	For State Registrar	State of N	Maryla		artmer rtificat				ental Hy		200) 4	085	5.5
1	s Dhuaicia	F	1. Decedent's Name (First, Middle, I	Last)							2. Date of D		v Ye	ar	3. Time of Dea	
	Physicia /Medica			arles	Peet	<u>.</u>					March				10:10	ам
	Examine	er	4a. Facility Name (If not institution, g		er)				r Location	of Death		40	. County of [Death		
			Gilchrist Cer		Age (In vrs	. last birthday		OWSC 1 Year		24 Hrs.	8. Date of Bi	irth	Mary]	and	ice (State or For	reian
	uneral irector		385-24-9209	MXM 2□F	75	Yrs.	Months	Days	Hours	Min.	(Month, D	Year)	928	Counti Mic	ice (State or For y) higan	o gr
P	5		Usual Residence of Decedent 10a. State 10b. County		10- 0	. T										
laryla	shov a ba	ក	10a. State 10b. County Maryland Harfor	rd		ity, Town or L Joppa	ocation							10	d. Inside City Lir 1 ☐ Yes 2 🔀	
the M	28a-f	Director	10e. Street and Number			оорра	10f. Zip	Code				10g Cit	izen of Wha	t Count		
with	3a or	٥	415 Shore Drive	2				1085								
death	al', or itams 23a or 28a-f show Engraner musi be notified at	Funerai	11. Marital Status	12. Was Decede Armed Force		J.S. 13.				igin? (Spe	cify Yes or N Rican, etc.)		ted St	America	n Indian,	
36 after	or Its	Y Fu	1 ☐ Never Married 2 🖾 Married				1 Yes		Specify:		nican, etc./		Black, V			
)OO	natural',	d by	3 Widowed 4 Divorced	Year or Date	s:	16- 0						1 101 16	Specify: W			
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hydiene.	fedic fedic	Completed	15. Decedent's (Specify only highest of	grade completed)		(Give	dent's Usu kind of wo DO NOT u	rk done d	durina mos	t of workii	ng	16b. K	ind of Busine	ess/Indu	istry	
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Ind 21215-0036 be filed within 72 hours after death with the Maryland lat Hydiene.	d other than "nature	Be	17. Father's Name (First, Middle, La Percy Phillips	st)					_		(First, Middle					
aryla should b	arke atic	ို	• •								F. Phil					
Mar 12 sh h and	27 is marked orby. than " r traumatic event, the Me.		19a. Informant's Name/Relationship Elisabeth Peet/Wi			111					Route Numb	-		e, Zip C	Code)	
e, P	٤ ۽		Clisabeth Peet/Wife 415 Shore Drive Jopp 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory of other place)								Maryla		cation - City	or Tow	n State	
Pages Pent of 1	y or o		1 X X Data in a la l							2/11	- 10001					
Baltir permit. P Departme			21. Signature of Euneral Service Licensee 22. Name and Address of Facility										and			
De Pe	E & S		· otephenu	2/16	asse	227 70	Duda	-Rucl	k Fun	eral	HOme o	of Du	ındalk	, Ir	nc.	
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caus ly one cause on each	sed the dea	th. Do not en	ter the mod	e of dyin	g, such as	cardiac o	Interval Between					
100	sician		Immediate Cause (Final disease or condition	. Amy	abrobo	hie L	adera	1 30	ieros	515					Onset and Death	1
	edical miner		resulting in death)	Due to (or				,						0		
Mily st.	Page 1	-	Sequentially list conditions,	Due to (or a	as a conse	quence of):										
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artifica	ing pl	Med	IF FEMALE:									- 1				
death certificate be executed	attending phy for use as th	by Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom	2 Fet	al death 3	Ectopic pr					1	23d. Date of Month	,	ay Year	
	ched:	ysic	1 Yes 2 No	4☐ Pregnant 9☐ Unknown		death 5L	Other (sp	өспу)							,	
requires that the	igned by the a	۲. ا	Part II. Other significant conditions	contributing to death	but not re	sulting in the u	ınderlying c	ause give	en in Part I		23e. Did t	tobacco u	se contribute	e to the	cause of death?	?
quires							_				1 🗆	Yes 2	☑ No 3 🗆	Probab	oly 4 DUnkno	nwc
law rec	s been s	ojete									24a. Was		24b. Were	autops	y findings availa	able
e e	page 2	Completed										psy ormed? 2 2 No	prior death	1?	pletion of cause	of
	# 5	Be C	25. Was case referred to medical examiner?						26. Place	of Death	(Check only			53 5	ESQ 10	
Physician: T	Pis I	0	1 ☐ Yes 2 No	Hospital: 1 🗆 Inpa		ER/Outpatie	nt 3 DC	Othe	er: 4 □ Nu	rsing Hor	ne 5□Resi	idence 6	ther (S	pecity)	105PICE)
D LIO	After the funeral	Certification:	27. Manner of Death ∫SNatural 5 ☐ Pending	Anner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28b. Matural 5 □ Pending (Month, Day Year) Injury Work?							8d. Describe	how injur	y occurred			
VISION OF Attending Physic death.	the i	cat	2 Accident investigat 3 Suicide 6 Could not	be Ose Blees of I	loius, - At h	ome farm et	M factor		Yes 2 □		Of Location (Ctroot an	d Alumbar ar	Durali	Tarida Alimahan	
= 5 ¥	itled in by the	ert	4 Homicide determine	building,	etc. (Speci	ify)	reet, ractory	, опісе		2	City or To	wn. State,) Number or	Hurair	Route Number,	
lospital	rilled		29a. Certifier 1 Certifying I	hysician: To the be	st of my kn	owledge, deat	h occurred	at the tim	ne, date an	d place, a	nd due to the	cause(s)	and manner	as stat	ed.	-
the Ho	To the Funeral Completely filled i	edicai	(Check only 2 Medical Ex	aminer: On the basis and manner	of examina	ation and/or in	vestigation	in my op	oinion, dea	th occurre	d at the time,	date and	place, and o	due to th	ne cause(s)	
To th	To tl comp	ž	29b. Signature and title of certifier						number			29d. Date	e signed (Mo	onth, Da	y, Year)	
1			> yan av	Lung			D	53	830	3		Man	ch 11	20	04	
7			30. Name and address of person wh			m 23a) (Type.	Print)	, (T- R	214	more	Ins) 7/2	C)2 ±		
			7.10/13.00		660	1 10.0	VIOU TE	د ر	1 2	~ In	more	1000	- 412	4		
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			1- State of Maryla Registrer		artment of Hea		ntal Hygie	- 2006	08556
	Physic		Decedent's Name (First, Middle, Last) Josephine Rhea				Date of Death Month	Day Year 5 2004	3. Time of Death
	/Medi Examii Funeral		4a. Fecility Name (If not institution, give street and number) FORK IN SQUARE HOSPI- 5. Social Security Number 6. Sex 7. Age (In vis.)	s. last birthday)		Lote	Date of Birth (Month, Day, Ye BY 8, 19	40 County of Deeth	1
ı	Director		Usual Residence of Decedent	69 Yrs. City, Town or Lo		Ma	ay 8, 19		essee
	ith the Maryland or 28e-f ehow e notified at	Director	Maryland Baltimore Mi 10e. Street and Number	iddle R	iver		10g.	Citizen of What Cou	1 Tyes 2 No
	er death wi Iteme 23a ner musi b	Funeral D	31 Compass Road 11. Marital Status 12. Was Decedent Ever in Armed Forces? 13. Naver Marital 3. A. Mariad	U.S. 13.	Was Decedent of Hispa If Yes, specify Cuban, N		Yes or No- an, etc.)	USA 14. Race - Americ Black, White,	can Indian,
P. 5-0036	within 72 hours after one. then "natural; or Iter	by	1 Never Married 2 Married 1 Yes 2 Mo If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed)	16a. Dece	1 Yes 2 No S	Specify:	16b	Specify: Wh:	ite
Josephine Maryland 21215-10136	be filed within 72 hattal Hygiene. Id other than "natuevant, it a Medical	Completed	Elementary/Secondary (0-12) College (1-4or 5+) 8 17. Father's Name (First, Middle, Last)	life.	DO NOT use retired) Nursery Sch			Day Care	
oset	2 should be fand Mental Is marked o	To Be	Walter Waits 19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Street and	Bertha	a St	orme	Code)
	ges 1 and 2 should nt of Health and Mer if Item 27 is marke or other traumatic		Gary Rhea (son) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State	. Place of Dispo	07 Swift Ru esition (Name of matory or other place)	un Court A	Abingdon	Md 21009	
Rhead	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tra once.		14 Donation 5 Other (Specify) 21. Signature of Funeral Service License	22	11 Mem. Gar	f Facility Bruzo	dzinski	Funeral H	
•	Physician /Medical Examiner		23a Pant. Enter the disease, or complications that caused the deal shoot, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. 589515 Due to (or as a conse	ath. Do not ent	407 Old Eas				Approximate Interval Between Onset and Death
68760	ificate be executed g physician and as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to time builds cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a conse						
P.O. Box	ath cert	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregr 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	tal death 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ery Day Year
ords P	w requires that the de been signed by the a should be detached f	þ	Part II. Other significant conditions contributing to death but not re	sulting in the u	nderlying cause given in	ı Part I.	_	use contribute to the	
Vital Becords	The law ate has b page 2 s	Completed					24a. Was an autopsy performed? 1 Yes 22	prior to cor death?	psy findings available inpletion of cause of 2 No
2 0	Phys rat di	ation: To Be	27. Manner of Death 1	□ ER/Outpatien 28b. Time of Injury	t 3 DOA Other: 4	28d.		6 Other (Specify	<i>(</i>)
Division	oital or Atte urs after de real Directo	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At the building, etc. (Special Country)	city)			City or Town, Sta		
	To the Hospital within 24 hours a To the Funeral completely filled	Medical	29a. Certifier (Check only one) Medical Examine So the basis of examination manner stated.	owledge, death ation and/or inv	occurred at the time, divestigation, in my opinion	on, death occurred a	t the time, date a	(s) and manner as st nd place, and due to Date signed (Month, I	the cause(s)
	×= ×		30. Name and address of person who completed cause of death (Ite	em 23a) (Type			1	-15-2 ,MIZIZ	
	Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar's Sign	11 39W	0	e Balti	MOLE	M1212	37
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	and *		Usual Residence of Decedent 10a. State 10b. County		10c. City. 1	Town or Lo	cation							100	d. Inside City	/ Limits
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920	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or itams 23a or 28a-f ehow event. Its Medical Fracial er med te notified at	by Funeral Director	11. Marital Status 1 ☑ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:	No		Was Deced If Yes, spec 1 ☐ Yes 2	/	spanic Origin, Mexican Specify:	gin? (Speci i, Puerto Ri	fy Yes or No- can, etc.)		14. Race - Ai Black, W Specify: Wh			
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Ma	127 F		Joyce Kelly/Mot		7						Fallst				,oue)	
Baltimore,	0 0	300	20a. Method of Disposition 1 □ Burial 2 ☑ Cremation	3 □Removal from State	20b. Plac	e of Dispo	sition (Nan natory or o	ne of		Dat			cation - City		n, State	
Itim		9	* 4 ☐ Donation 5 ☐ Other (Sp. 21. Signature of Funeral Service L		Ches	_	ke Cr			20		Belt	sville	e, M	MD	
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rds, P.	w requires that been signed by should be deta	by	Part II. Other significant conditio	ns contributing to death	but not resultir	ng in the ur	nderlying ca	ause give	n in Part I.				se contribute		6	ath?
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	ling After une	atlon; To	27. Manner of D ath 1 Matural 5 Pending 2 Accident investig		ury 28	Bb. Time of Injury		Bc. Injury Work	at Nu	28	5 ☐ Resid d. Describe h			pecify)		
Division	Diffe	Certification;	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 286. Place of in	jury - At home tc. <i>(Specify)</i>	e, farm, str	eet, factory	, office		28	f. Location (S City or Tow	itreet and n, State)	d Number or (Rural F	Route Numb	er,
	To the Hospital within 24 hours a To the Funeral completely filled	edical	29a. Certifier 1 Certifying (Check only one)	g Physician: To the best Examiner: On the basis of and manner s	of examination	edge, death n and/or inv	occurred a vestigation,	at the time in my opi	e, date and inion, deat	d place, and th occurred	d due to the d at the time, o	ause(s) date and	and manner place, and d	as state ue to th	ed. ne cause(s)	
	To th within To th compl	Me	29b. Signature and title of certifier	1	Υ	0 .	29c	License		200			e signed (Mo			17
	ix	1	30. Name and address of person v	who completed cause of	death (Item 23	3a) (Type	Print)	ソ			3			ĺ,	1, 200	7 -
	11			NAVI	M	17	NHI	2,1	SAL	-TO.	Mp.	211:	33			
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	/Medic Examin	_	4a. Facility Name (If not institution, give		4b. 0	City, Town, or Location Baltimo			4c. County	of Death	
	Funeral		1200 N. Bond Stre		Mon	nder 1 Year If Und	er 24 Hrs. g	Date of Bird (Month, Da	iv. Year)	9. Birthple	ce (State or Foreign
	Director		Usual Residence of Decedent	- LI	Yrs.		F	vaust	29,1982	INTHE	CYLAND
	Aaryland I show	o	10a. State 10b. County	_ ^ ′	, Town or Localion HUTIMDR	F.				100	d. Inside City Limits 1 1 Yes 2 ☐ No
	ith the h or 28a-	Funeral Director	10e. Street and Number			. Zip Code	. 07.		10g. Citizen of W		ry?
	leath wi	eral [3709 BAYON	VE AVE. 12. Was Decedent Eyer in U.S	S. 13. Was D	ecedent of Hispanic specify Cyban, Mexic	Origin? (Speci	fy Yes or No		5.A. - America: k, While, el	
36	hours after death with the Maryland turer, or frems 23e or 28e-f show al Examiner must be rediffed at	by Fun	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		specify Cyban, Mexic is 2 No Speci		can, etc.)	Specify.	LAIA	HCK
5-00	72 hour	eted l	15. Decedent's Ed (Specify only highest gra	lucation	16a. Decedent's (Give kind o	Usual Occupation f work done during m T use retired)	nost of working	7	16b. Kind of Bu	siness/Indu	ustry
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A Pro	2 should a and Men		pa. GWARA NICKRALISTIP S	ALACE MOTHER	19b. Mailing Add	tess (Street and Num	nber or Rural			State, Zip C	Code) JANO 2120U
o d	ges 1 and 2 it of Health If item 27 or other tra		20a. Melhod of Disposition	. Ce	lace of Disposition emetery, crematory	(Name of or other place)	Da	-	20c. Location -		
Raltimore	permit. Pages Department of I Important: If it any injury or o		1 Surial 2 Cremation 3 C) KIN	16 HEMOR	ACPARK e and Address of Fa	3.18	. 04	BATIMO	RE, 1	UARYLAND ELAZ HOME
a	permit. Pa Departmen Important: any injury once.		21. Signature of Funeral Service Licen	An Frese	4909	5 YORK	ROMO	BACT	imore, 1	MARY	(AND 21212
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89	eath certifica attending ph	/Medi	IF FEMALE:	23c. If yes, outcome of pregna	incy				23d. Dat	e of deliver	у
Box	Physician: The law requires that the death certificate be executed risk certificate has been signed by the attending physicien and rail director, page 2 should be detached for use as the burial-transit	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown		r (specify)			Mor	nth [Day Year
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leti/	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:			ace of Death	(Check only	one)		At scene
	g Phys er this neral dir	n: To	1 No 27. Manner of Death	28a. Dale of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28		how injury occurr		At scene
	Attending F r death. ector: After by the funera	catio	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not b	3/12/04	2:34 P M	1 🗌 Yes 2	ZNO	Bf. Location ((Street and Numb		
Ø	s after al Direct	Certification:	4 SHomicide determined	STREET	y) 			on suk			T, BACTLINORE, H
\	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page	Medical	29a. Certifier 1 Certifying Pt (Check only 2 Medical Examone)	nysician: To the best of my kno miner: On the basis of examina and manner stated.	owledge, death occu tion and/or investig	irred at the time, date ation, in my opinion,	and place, ar death occurre	nd due to the d at the time,	cause(s) and ma , date and place, a	nner as sta and due to	ated. the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier			29c. License numb	er E.		29d. Date signed March I	3, 20	Year)
	3		30. Name and address of person who	completed cause of death (Item	n 23a) (Type, Print)	111 Penn	Street	Balt	imore, M	aryla	nd 21201
	St	ate	ANA KUR 31. Date filed (Month, Day, Year) IIIAR 1 7 2004	32. Registrar's Signa	ature						
	Regist		mrsn 1 / 2004	Soul &	direction .						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 12:10 PM **Physician** 2004 SERNADETTE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Paltimore Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign 6. Sex (In yrs. last birthday, 5. Social Security **Funeral** Days 1 ☐ M 2 🔀 F Director Usual Residence of 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10b. County 10a, State Department of Health and Mental Hygiene. Important: or items 23s or 28s-f ehow important: if item 27 is marked other then "natural", or items 23s or 28s-f ehow eny injury or other traumatic event, the Medical Examinat must be notitled at 1 Yes 2 No Completed by Funeral Director MORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates: 3. Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) condary (0-12) College (1-4or 5+) Medical Pages 1 and 2 should be filed venent of Health and Mental Hygie ant: If Item 27 to marked other? 17. Fat 's Name (First, Middle, Last) Be 19b. Mailing Address (Street and Number or Rural Route Number 20c. Location - City or Town, State 20a. Method of Disposition

1 Burial 2 Cremation 3 8

4 Donation 5 Other (Specify) 3 Removal from State 21. Signature of Funeral Service Licenses Dermit. 4D 21229 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. such as cardiac or respiratory arrest, Immediate Cause (Final SDEMK **Physician** HOUVS UC MON ARY resulting in death) /Medical Due to (or as a consequence of): Examiner I & CHEMIC 1 comes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner burial-transli The law requires that the death certificate be executed V wars ORONANU Due to (or as a consequence of): Box 68760. YERMS TONSCO the as IF FEMALE: 950 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 Yes 2 No
9 Unknown 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Be Completed by 1 Yes 2 No 3 Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s 1 Tes 2 No Division of Vital To the Hospital or Attending Physician: 25. Was case reterred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 2 ☐ ER/Outpatient 3X DOA 5 Residence 6 ☐Other (Specify) 2 1 🗌 Yes 2**%** No 1 Inpatient After thi 28c. Injury at Work? Date of Injury (Month, Day Year, 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29d. Date signed (Month, Day, Year) 29c. License number nd title of certifier 29b. Signature D0035468 10,2004 MS n 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 201425 PWAIL MD Buttinove 600 to velace 31. Date liled (Month, Pay, Year) WAR 1 7 2004 932. Registrar's Signature State Registrar

		Registrar 1. Decedent's Name (First, Middle, Li	ast)	Ce	ertificate of	Death	2. Date of De	Reg. No. 2 (
Physic /Medi		Ada Mae Robey	231)				Month MARCH	Day	Yeer 2004 (2 15
Exami	ner	4a. Facility Name (If not institution, gi				or Location of Dea		4c. County	
Funeral	•		MEDICAL (INTER (In yrs. last birthday		If Under 24 Hrs		ANNE	
Director		214-12-7909	1 □ M 2 WE	1 Yrs.	Months Days	Hours Min		ay, Year)	9. Birthplece (State or Fi Country) Beltsville,
*		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				
feda	tor	MD Queen A	nne	Stevensv					10d. Inside City L
or 28a a noti	irec	10e. Street and Number		beevensy	10f. Zip Code			10g. Citizen of V	What Country?
23a c	raiD	125 Utah Road			21666	i		USA	
nar rygiene. id other than "natural", or flems 23a or 28a-f show event. I'ra Medical Evantinar musi ke notified at	Funeral Director	11. Marital Status	12. Was Decedent E Armed Forces?		. Was Decedent of H If Yes, specify Cub	Hispanic Origin? (S ban, Mexican, Puer	Specify Yes or No to Rican, etc.)	14. Rac Blac	e - American Indian, ck, White, etc.
0	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐N If Yes, Give Year or Dates:	0	1 ☐ Yes 2 █ No	Specify:		Specify	white
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han.	mpi	Elementary/Secondary (0-12)	College (1-4or 5-	+) life.	DO NOT use retire	nd)	rking		
narked other than marked other than imatic event, Ita M		17. Father's Name (First, Middle, Last	t)		Homemaker	T	me /First Middle	priva Maiden Sumam	
and Mental is marked c aumatic eve	To Be	Elbert Beckwith					eth Marg		(-)
really and wenter them 27 is market other traumatic		19a. Informant's Name/Relationship ((Type, Print)	19b. Mail	ling Address (Street				State, Zip Code)
item 27 other tra		George E. Robey			Utah Rd.	Stevens	ville, M	D 21666	5
o == 5		20a. Method of Disposition 1 ₩ Burial 2 □ Cremation 3 □		1	matory or other place	· ·	Date		City or Town, State
Department Important: Il any injury o		* 4 □ Donation 5 □ Other (Special 21. Signature of Funeral Service Lies	A	Fort Line	coln Ceme	tery 03-	17-2004	Brentwo	ood, MD
Departm importal any inju		21. Signature of Furnação Servino Elos	The	2	2. Name and Addre	ess of Facility Ft	Lincol	n Funera	1 Home
p		23a. Part1. Enter the disease, or com	oplications that caused t		3401 Blad	enspurg i	ka Bren	twood, M	1D 20722
		shock, or heart failure. List only		ne death. Do not en	iter the mode of dvir	ng, such as cardia	or respiratory ar	rrest	Approximate
vsician		Immediate Cause (Final	one cause on each line	ž.		ng, such as cardia			Approximate Interval Between Onset and Deat
ledical		-	a. Chron	ž.	huctive	ng, such as cardia			Approximate Interval Between Onset and Deat 15 years
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	Physici		1. Decedent's Name (First, Middle, Last) Charles Rappe				Month MARCH 1	Day '	Year 8:55a M	A
	/Medic		4a. Facility Name (If not institution, give street and number)		4b. City, Town,	, or Location of Death		4c. County o		-
	Examin	er	GOOD SAMARITAN HOSPITAL			ORE CITY		1	JA	
	Funeral		5. Social Security Number 6. Sex 7. Age (In	yrs. last birthday)	If Under 1 Year Months Day		8. Date of Birth (Month, Day,	Year)	9. Birthplece (State or Foreign Country)	n
2	Director		217-54-9572 20F 3	9 Yrs.	Wioritals Day	3 110013 141111	Feb 18,	1965	PA.	_
	and w		Usuel Residence of Decedent 10a. State 10b. County 10c	c. City, Town or Lo	cation .				10d. Inside City Limits	5
	the Marylan 28a-f show	ō	MD NA		BALTIMO	see			1 Ves 2 No	٥
	28a-	rec	10e. Street and Number		10f. Zip Code		1	0g. Citizen of Wi		
	23a or	a D	2808 ROSALIE AVE			21234		V.3	S. A.	
	filed within 72 hours after death with the Maryland Hygiene. ther than "naturel", or Items 23a or 28e-f show ther than madical Examiner must be incitified at	Funeral Director	11. Marital Status 12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of f Yes, specify Cu	f Hispanic Origin? (Sp Jban, Mexican, Puerto	pecify Yes or No- Rican, etc.)		- American Indian, , White, etc.	
36	s afte	by Ft	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ N	Specify:		Specify:	white	
8	72 hours "naturel",	ed b	15. Decedent's Education	16a. Deced	ient's Usual Occ	upation		16b. Kind of Bus	iness/Industry	
15	nin 72 n "ne	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give	kind of work dor OO NOT use reti	ne during most of work red)	king		_	
212	d with giene ar tha	E	9+6 NA		YL	-umber		Sel		_
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√a	ould i	ဥ	HOWARD RAPPE	405 14-15	- 6 dd /000	MAR GAL et and Number or Ru			tato Zin Codo)	
Mar	s 1 and 2 should be filed within 72 hours after death with the Maryla Health and Mental Hygiene. Item 27 is marked other than "naturel", or Items 23e or 28a-1 sho tother traumatic event, the Medical Examiner man be multised at		19a. Informant's Name/Relationship (Type, Print) WARGARUT RAPPE	400	•	IA CT.			1204	
<u>6</u>	1 and Healt tem 2			Ob. Place of Dispo	sition (Name of	-		*	lity or Town, State	_
Ω	ages ant of nt: If it		1 Burial 2 Cremation 3 Removal from State	BAYVICW	C Cema To	Ry 3/17	1/04	BAlto.	MD.	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 3 Department of Health Importent: If Item 27 eny injury or other tr once.		21. Signature of Funeral Service Licensee	22	Name and Add	ress of Facility	rella Fun	eral Ito	me CHTD	
8	89 = 8		Jan M. Stilla	73	127 hal	FORP RID.	130 170. 1	N) die	7	
银			23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.				or respiratory arre	est,	Approximate Interval Between Onset and Death	
G. P.	Physician		Immediate Cause (Final disease or condition resulting in death) Complication a.	s of Diabe	tes Melli	tus				_
	/Medical Examiner		Due to (or as a co	nsequence of):						
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	d d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events							
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P.O.	that the death ed by the atte detached for	ysic	1 Yes 2 No 9 Unknown							
	es that gned b	by PI	Part II. Other significant conditions contributing to death but no	t resulting in the u	nderlying cause	given in Part I.	23e. Did tot		oute to the cause of death?	
rds	v requires been signi should be						1 🗆 Ye	es 2/2/No 3	Probably 4 Unknown	a —
000	law re as be 2 sho	piet					24a. Was a autops	n 24b. W	ere autopsy findings available for to completion of cause of ath? Yes 2 \(\subseteq \text{No} \)	0
Ä	The Cate has page	Completed					perform 1 X Yes	ned? de 2□ No 1	ath? Yes 2□ No	_
Division of Vital Records,	ysician: The is certificate director, pag	Be	25. Was case referred to medical examiner? 12 Yes 2 \sum No Hospital: 1 \sum Inpatient	37		Than	th (Check only on			_
of	Physical this cral dir	.T	1 Yes 2 No No No I I I I I I I I I I I I I I I	2 ER/Outpatier	IL SLI DOA	4 Nursing n	ome 5 Reside			_
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	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the		29a. Certifier (Check only Check only (Check only Check only	y knowledge, deat mination and/or in	n occurred at the	time, date and place y opinion, death occu	, and due to the carred at the time, d	ause(s) and man ate and place, ar	ner as stated. nd due to the cause(s)	
	the hin 24 the F	Medical	one) and manner stated. 29b. Signature and title of certified	4	29c. Lice	ense number	2	9d. Date signed	(Month, Day, Year)	_
	Wit To	_	b land	1		OCME	F	ARCH 16		
			30. Name and address of person who completed cause of death	(Item 23a) (Type,	Print)					
			S.R.HOENAN		111 Pe	nn Street,	Baltimo	re, Mary	yland 21201	_
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's	Signature						
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			For State Registrar	S	tate of	Marylan					ealth a Death	and M		Reg. No. 2	004	08562
		ŵ.	1. Decedent's Name (First, Middle	, Last)	-					_			2. Date of Dea Month	ath Day	Year	3. Time of Death
	Physici: /Medic		Clarence E. Ra										March	13, 20		6:15 p. M
	Examin		4a. Facility Name (If not institution					4			Location of	f Death			ty of Death	_
			2017 Kelbourne	Road 6. Sex		it 202 . Age (In yrs.	la et hiet	hdayl	ROS If Under	edal	Le If Under:	24 Hrs.	8. Date of Birt		timore	
	Funeral		5. Social Security Number 216-12-2701		2 🗆 F	. Age (<i>iii yis</i> .			Months	Days	Hours	Min.	(Month, Da	y, Ye <i>ar)</i>		place (State or Foreign ntry) Cyland
	Director		Usual Residence of Decedent										Aug. I	0, 1010		
	yland		10a. State 10b. County			10c. Ci	ty, Town	or Loca	ation							10d. Inside City Limits 1 ☐ Yes Z No
	e-f st	ctor	Maryland Balt	imore	e	Ros	seda	le								
	or 28	Director	10e. Street and Number						10f. Zip					10g. Citizen o		•
	ath w 23s		2017 Kelbourne					10.111	212			-i-2 /C	aifu Van ar Na	United	ace - Amen	
	ours after death with the Marylan ral', or items 23e or 28e-f show Ever it we must be notified at	Funerai	11. Marital Status		Amed Ford	2 LJ NO		1			n, Mexican	gin? (Spe i, Puerto	cify Yes or No Rican, etc.)	BI	lack, White	
36	rs aft	by F	1 ☐ Never Married 2 ☐ Mar 3 🖄 Widowed 4 ☐ Divorced		Il Yes, Give Year or Da	- WW	II	1 [□Yes 2	2 ½ No	Specify:			Spec	wh	ite
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nd	be filed ital Hygi of other event, I	Be	17. Father's Name (First, Middle,	Last)									(First, Middle,	Maiden Suma	атө)	
Maryland	D 9 2 0	은	Elmer Raines	hin Cinn	Driet)		10h	Mailing	Addross	/Street			artin <i>I Route Numbe</i>	er City or Tow	m State Zi	n Code)
Mai	12 h a 7 ls		19a. Informant's Name/Relations Joe Redington								Stree					· Consequences
	1 en deal deal deal ther		20a. Method of Disposition	(ме	ohew)	20b.			ition (Nan				ate B	20c. Location		1. 21224 own, State
ğ	not of or	3	1 Burial 2 Cremation 1 Donation 5 Other (oval from S	state					sus 3	/16/	2004	Raltir	more	Maryland
Baltimore,	permit. Pag Department Importent: I any injury o	1	21. Signature of Funeral Service	-		7		22.	Name an	d Addres	s of Facilit	lv				
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	8.4 4"		23a. Part1. Enter the disease, o shock, or heart failure. Lis	r complicat	tions that ce	eused the dea	th. Do r	ot enter	r the mod	e of dyin	g, such as	cardiac o	or respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	only one	Wel		4	ماري	m (im	ar					Onset and Death
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	death a atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No		4⊟Pregna	irth 2 ☐ Fet ant at time of			Other (sp						Month	Day Year
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o,	The law requires that the death certifica tte has been signed by the attending ph page 2 should be detached for use as th	by P	Part II. Other significant condit	ions contri	buting to de	ath but not re	sulting ir	the und	derlying o	ause giv	en in Part I	1.	_	1.7		the cause of death?
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Ď	after Dire	Certification:	4 Homicide	tillied.	buildir	ng, etc. (Spec	eify)						City or To	wn, State)		
	To the Hospitel or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	Medical C	29a. Certifier 1 Certify (Check only 2 Medics	ing Physic I Examine	r: On the ba	best of my kr asis of examir ner stated.	nowledge nation an	e, death	occurred estigation	at the tir n, in my o	ne, date ar pinion, dea	nd place, ath occur	and due to the red at the time,	cause(s) and date and place	manner as e, and due	stated. to the cause(s)
	To the within 2 To the complex	Me	29b. Signature and title of certif	er					29	c. Licens	se number			29d. Date sig	ned (Month	o, Day, Year)
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	140		30. Name and address of person	n who com	pleted caus	se of death (Ite	em 23a)	(Туре, Р						imi	- 1	
1	07.		Robert Dist	_ ¬	stelle	1 000	too	0.0	101	Ro	1. 7	3celf	imure	illi	217	219
	St	ate	31. Date liled (Month, Day, Yea		32: A	egistrar's Sigr	nature	A CONTRACTOR OF THE PARTY OF TH	aff.							
	Regist	rar	MAR 1	2004	P. ale	1560	130	100	Ses Selver							

State of Maryland / Department of Health and Mental Hygiene State Registrar AMEND ITEM #10c PER FH G829 3/17/04 Contribute of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) MARCH 14, 2004 **Physician** 2:06 P MILTON /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE BALTIMORE 130 SLADE AVENUE #324 If Under 24 Hrs. 8. Date of Birth Hours Min. MAY 3, 1920 Birthplace (State or Foreign Country) If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days 1 M 2□ F MD 83 Yrs Director 220-05-4128 Usual Residence of Decedent Peges 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Interm of Heatth and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Itams 23a or 28e-f ehow 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County item 27 is marked other than "natural", or Itams 23e or 28e-f show other traumatic event, the Medical Examinating must be notified at 1 ☐ Yes 2 ☑ No BALTIMORE PIKESVILLE Director MD BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21208 130 SLADE AVENUE #324 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XXYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2X Married WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify. à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) U.S. ARMY CHIEF WARRANT OFFICER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be NARUNSKY COHEN MORRIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2602 GAGE COURT #D - BALTIMORE, MD 21208 GILBERT COHEN / BROTHER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Peges 1
Department of H
Important: If ite
eny injury or ot
once. 1 Burial 2 Cremation 3 Removal from State BALTIMORE HEBREW CEM. 3/15/2004 REISTERSTOWN, MD * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence, of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires thet the death certificate be executed the attending physicien and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months?

1 Yes 2 No
9 Unknown 5 ☐ Other (specify) 4□Pregnant at time of death 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ funeral director, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No has certificate 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DDA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident the 1 within 24 hours after deat To the Funeral Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 7 2004 Registrar

DHMH 17 Rev 1/2001

				1 - State of Maryland / Department of Health an Certificate of Death		Reg. No. ZUU	08565
_		Physici		1. Decedent's Name (First, Middle, Last) Petra Maria Robosson	2. Date of De. Month March	Day Year	3. Time of Death 9:45 AM M
		/Medio Examir		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of C		4c. County of Dea	
			*	Upper Chesapeake Medical Center Bel Air		Harfo	
	P	Funeral			Min. 8. Date of Bird (Month, Da July 2	v. Year) C	thptace (State or Foreign ountry)
		Director		217-52-9181 Usual Residence of Decedent	July 2	9, 1943 G	ermany
		nyland how		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
		the Marylan r 28e-f show rolling at	cto	Maryland Harford Abingdon			1 ☐ Yes 2 🗗 No
		with the	Funeral Director	10e. Street and Number 10f. Zip Code		10g. Citizen of What C	ountry?
5		eath w	eral	3622 Longridge Court 21009 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin	1? (Specify Yes or No	Germa 14. Race - Am	
348	9	after or Item	Fun	Armed Forces? If Yes, specify Cuban, Mexican, F 1 Never Married 2 Marned 1	Puerto Rican, etc.)		te, etc.
0	03	72 hours after death with the Maryland natural', or Items 23a or 28e-f show distal Examinet fount be rodified at	d by	3 ☑ Widowed 4 □ Divorced If Yes, Give Year or Dates:		Specify:	White
	15-0	72 hours "natural",	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of life. DO NOT use retired)	f working	16b. Kind of Business	s/Industry
	12	within iene then	duic	Elementary/Secondary (0-12) College (1-4or 5+) 12 Sales		Ames	
	d 2	filled Hygi other	Be C		Name (First, Middle,		
	/lan	uld be Venta irked itic sv	To B	Frantz (unk) Langer Lisa	lotta (unk) (unk)	
104	Maryland 21215-0036	and 2 should be filed within salth and Mental Hygiene n 27 ls marked other than 'er treumatic sysnt, the Mar		19a. Informant's Name/Relationship (Type, Print) Lilo A. Moskos / Daughter 19b. Mailing Address (Street and Number of 3622 Longridge Ct.			Zip Code)
112	altimore,	permit. Pages 1 and 2 Department of Health Important: If Item 27 I sny injury or other tre		20a. Method of Disposition 1 □ Burial 2 反 Cremation 3 □ Removal from State	Date 12.04	20c. Location - City o	
(1)	Ħ	artme ortant injury		4 Donation 5 Other (Specify) 21. Signal we by Funerary Service Rose 22. Name and Address of Facility 22. Name and Address of Facility		Towson, Ma	ryland
	Ba	Per Pep Pep Pep Pep		McComas Funeral 1317 Cokesbury	Road. Abin	adon. MD 2	1009
				23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as ca shock, or heart failure. List only one cause on each line.	rdiac or respiratory a	rrest,	Approximate Interval Between Onset and Death
	× 100	Physician		Immediate Cause (Final disease or condition a PNEV MONIA			Onset and Death
	Ř.	/Medical Examiner		resulting in death) Due to (or as a consequence of):	CICTURE	^	
00			er	if any, leading to immediate Due to (or as a consequence of):	113100	4	
		uted d ansit	Examiner	Sequentially list our diffusis, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events C. HAGEAC CANCEL			2 Howan 8
3402	ó	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit		resulting in death) Last Due to (or as a consequence of):			1 - 5110
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,	39 >	e as t	Med	IF FEMALE:			
	Во	eath certifica attending ph I for use as th	Physician/Med	23b. Was decedent pregnant on the cast 12 months? 23c. If yes, outcome of pregnancy 1		23d. Date of do Month	elivery Day Year
	o.	res that the de signed by the a be detached t	ysic	1 Yes 2500 4 Pregnant at time of death 5 Other (specify)9 Unknown			
	٦	that the		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did t	obacco use contribute	to the cause of death?
	rds	w requires been sign should be	d be	CHRONIC OBSTRUCTIVE PULMONAM DISEASE	10	Yes 2 □ No 3 □ F	Probably 4 Munknown
4	of Vital Records, P.O. Box 6	aw re	Completed by	•	24a. Was		autopsy findings available completion of cause of
Petra	Ä		E O		perfo	rmed? death?	
0	/ita	cian: artific actor,	Be	ayaminar?	f Death (Check only o		
D	of \	hysi this c	70	1 Yes 25 No Hospital: Inpatient 2 ER/Outpatient 3 DOA Other 4 Nurs		dence 6 ☐ Other (Sp	ecify)
0.0	no	Attanding Physician: r death. sctor: Atter this certifics by the funeral director; p	tlon:	27. Manner of Death Salaturat 5 □ Pending (Month, Day Year) (Month, Day Year) Month Mont		how injury occurred	
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00	ā	al or a safter	Serti	4 ☐ Homicide determined building, etc. (Specify)	City or To	wn, State)	
Robusson,		To the Hospital or Attandi within 24 hours after death. To the Funeral Director; A completely filled in by the fu	Medical Certification:	29a. Certifying Physicien: To the best of my knowledge, death occurred at the time, date and concept of the control one) 2 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and making the control of the control	place, and due to the occurred at the time,	cause(s) and manner a date and place, and du	as stated. ue to the cause(s)
		To the within 2 To the comple	Ĭ	29b. Signature and title of certifier 29c. License number		29d. Date signed (Mor	
		3		Man 20 H55922	7554 6 21-7 0	MARCH 12 PEAKE DA	, 2004
)		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 UPF ANDIONY W. SAMPALUPO DO BEL	AIR M	D ZIOI	7-
		Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	7		
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		-	For State Registrar	State of Man		ertificate of		ental Hygie	20114	08566
			Decedent's Name (First, Middle, Last)	1) 1		\	2. Date of Death		3. Time of Death
	Physicia		Henry Sam	ies K	ioehi	ner.	Jr.	March	11,2004	11:40 PM
	/Medic Examin		to Engility Name of not institution give s	treet and number)	Extended		or Location of Death		4c. County of Death	
	 ;		Baltimore Rehabilit			JUIT	MOCE If Under 24 Hrs.	0.0	Baltimore	
	Funeral		5. Social Security Number 6. Sex	M 2 F	n yrs. last birthday Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Y	ear) Cou	pfece (State or Foreign intry)
	Director		215-14-8408 Usuel Residence of Decedent	8	4			Feb. 26,	1920 Nort	th Carolina
	yland how	. [10a. State 10b. County		Oc. City, Town or I					10d. Inside City Limits
	e Ma	Director	Maryland Anne Aru	ndel	Brook1yn					1 ☐ Yes 2 ☐ No
	or 28	Dire	10e. Street and Number			10f. Zip Code			. Citizen of What Cou	
	s 23a	ra	5323 Wasena Ave.	12. Was Decedent Eve	or in H.S. 12	21225	Hispanic Origin? (Spe		nited Stat	
	ter de Itam	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?	SF III 0.3.	If Yes, specify Cub	an, Mexican, Puerto	Rican, etc.)	Bfack, White	
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2	within 72 ho jiene. r then "natur ine Medical	mple	Elementary/Secondary (0-12)	College (1-4or 5+)	life	DO NOT use retire	ed)			
			17. Father's Name (First, Middle, Last)		Mec	hanic	18. Mother's Name	Ch (First, Middle, Ma		nufacturing
Maryland	be do do	o Be	Henry James Roeh	nor Sr			Mary A.			
7	d 2 should the and Meni	2	19a. Informant's Name/Relationship (Ty)		19b. Ma	ling Address (Street			City or Town, State, Zi	p Code)
	aith a 27 is		Henry James Roehne	r, III / S	on 3B	Raylon Dr	., Nottin	ham, MD	21236	
ore,	of Healt of Healt Item 2		20a. Method of Disposition 1√3Burial 2 ☐ Cremation 3 ☐R		20b. Place of Dis	position (Name of ematory or other pla	Ma:	n. 15,	c. Location - City or T	own, State
Ë	nit. Peges partment of I cortant: If It injury or o		'4 Donation 5 Other (Specify)			le MD Vet	. Cem.		rownsville	e, MD
Baltimore,	permit. Peg Department Important: any injury c		21. Signature of Funeral Service License	10		22. Name and Addr Kirklev-R	ess of Facility Auddick Fu	neral Hom	e P.A.	
_	005 e 0		23a. Part1. Enter the disease, or compli	cog/	4	_				21061 ate
Ŋ.	Q.Y.		shock, or heart failure. List only or	e carrie on each line.	1 -	nto to mo o o dy	71g, 50 - 03 02 01 01 00 0	n roophalory arros		Interval Between Onset and Death
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360	e law has t	mpi	15chemic (Avacou.	101/21	7		24a. Was an autopsy performe	prior to o death?	ompletion of cause of
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Vital	Physicien: this certificant	0 B	avaminer?	lospital:	2 ER/Outpat	ent 3 DOA Ct	han		ce 6 ☐Other (Spec	ify)
of		n: T	27. Manner of Death	28a. Date of Injury (Month, Day Y	/ear) 28b. Time		iry at	28d. Describe how	injury occurred	
Sior	Attending ir death. ector: After by the fune	atic	1 Naturaf 5 Pending 2 Accident investigation				Yes 2 □No			
Division	or Attendate death Director:	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	r - At home, farm, (Specify)	street, factory, office		28f. Location (Stre City or Town,	et and Number or Ru. State)	ral Route Number,
	pitel ours a erei D		29a, Certifier 12 Certifying Phys	sician: To the best of	my knowledge, de	ath occurred at the t	ime, date and place	and due to the cau	se(s) and manner as	stated
•	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	edical		ner: On the basis of eand manner state	xamination and/or					
35	Nithin Fo the Sompl	Me	29b. Signature and title of certifier	7		1	se number	1	d. Date signed (Month	
)	`		Winter	M	M	000	032549	1	larch 11,	2004
	· V		30. Name and address of person who co		th (Item 23a) (Typ	e, Print)	100.05	1-06	Baltin	yore, M)
			PERRY L COL	VIN M		10041410	reche)	77566	Datin	(,,,,)
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) MAR 1 7 2004	32. Registrar	3 digitation	Sporter				

DHMH 17 Rev 1/2001

		1 - State Registrar 1. Decedent's Name (First, Middle, La:			artment of Health an tificate of Death		g. No. 2001	3. Time of Dea		
ysici Nedio		Joseph Herman Sta	abile			Month	Day Year 15, 2004	1:01 F		
amir	ner	4a. Facility Name (If not institution, given 3905 Goose Harbon			4b. City, Town, or Location of E Middle River	Death	Baltimo:			
eral ctor		5. Social Security Number 6. S 220 14 7124 Usual Residence of Decedent	Sex 7. Age (In yrs.	last birthday) 78	If Under 1 Year If Under 24 Months Days Hours I	Min. (Month, Day,	Year) 9. Bir 925 Bal	rthplace (State or For country) to., Maryla		
1		10a. State 10b. County	10c. C	ity, Town or Lo	cation			10d. Inside City Lin		
office	Directo	Maryland Baltimore	e Mi	ddle Ri	Ver		og. Citizen of Whal C	1 Yes 2		
ag I	i Dir	3905 Goose Harbor	Road		21220	"				
T T	Funeral	11. Marital Status	12. Was Decedent Ever in L Armed Forces?	J.S. 13. V	Vas Decedent of Hispanic Origin I Yes, specify Cuban, Mexican, P	? (Specify Yes or No- querto Rican, etc.)	14. Race - Ame Black, Whi	erican Indian,		
edical Examinar must be notified at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 XYes 2 □ No If Yes, Give Year or Dates: WW 2		☐ Yes 2 No Specify:		Specify:	White		
Medica	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)		(Give	lent's Usual Occupation kind of work done during most of DO NOT use retired)	working	6b. Kind of Business	s/Industry		
event, the Ms		10		Equip	ment Operator	N== (5: 14:-14:- 1		Stainles		
•	To Be		tabile		Ma		tta			
9		19a. Informant's Name/Relationship (Hilda Geiger (sis	Type, Print) ster in Law)		g Address <i>(Street and Number o</i> Seneca Garden Ro					
other		20a. Method of Disposition	20b.	Place of Dispo	sition (Name of patory or other place)	-	Oc. Location - City or			
any injury or other tr once.		1 N Burial 2 □ Cremation 3 □ '4 □ Donation 5 □ Other (Specify	Intentoval from State	k Lawn	Cemetery Man	rch 18,2004	Baltimore	e, Maryla		
any inju		21. Signature of Funeral Service Licer	1588	22	Name and Address of Facility	Bruzdzinsk	i Funeral	Home PA		
el Ol		23a. Par 1. Enter the disease, or com	unlinations to accord the dea		07 Old Eastern			nd 21221 Approximate		
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iner		Due to (or as a consequence of): Due to (or as a consequence of): Disease Disease								
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	151	cause. Enter Underlying Cause (Disease or injury	C	quence or):						
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			For 1 State	State of Maryla	nd / Depa		lealth and	Mental Hyg	9	
	Physici /Medio Examir	al	1. Decedent's Name (First, Middle, Last) Charlene 4a. Facility Name (If not institution, give s Bayview Geriatric				or Location of Dea	2. Date of Dea Month March	ith Day	'ear //4/ A M
2	Funeral Director		5. Social Security Number 6. Sex		s. last birthday) Yrs.				7, Year) 1931 \	9. Birthplace (State or Foreign Country) 7irqinia
	h the Maryland r 28a-f show	Director	10a. State 10b. County Maryland Baltimore 10e. Street and Number		ity, Town or Lo				10g. Citizen of Wh	10d. Inside City Limits 1 ☐ Yes ※X No at Country?
92	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel; or itema 23a or 28a-f show any injury or other traumatic event, the Modical Examinant rule is notified at ODCs.	Funeral	1 Never Married 2 Married	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes ※No If Yes, Give	U.S. 13.	21220 Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 № 20		Specify Yes or No- to Rican, etc.)	U.S.A. 14. Race - Black, Specify:	American Indian, White, etc.
Maryland 21215-0036	within 72 hours ne. .han "naturel', e Mudical Exe	Completed by	3 ☐ Widowed 4 XX ivorced 15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	Year or Dates:	16a. Dece	dent's Usual Occup kind of work done DO NOT use retire	pation during most of we	orking	16b. Kind of Busi	•
yland 2	tould be filed volumental Hygie varked other thatic event, its	To Be Co	8 17. Father's Name (First, Middle, Last) Preston Fridley				Carthed		Maiden Sumame)	
ore, Mar	es 1 and 2 sh of Health and litem 27 ie m r other traum		19a. Informant's Name/Relationship (Ty) David Alton Strong 20a. Method of Disposition	(Son)	9011 Place of Dispo	ng Address (Street COWENTON position (Name of matory or other pla	Avenue,			land 21128
Baltimore,	permit. Page Department Importent: If any injury or once.		1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fuharal Sergical Econoce	Eb	enezer	Church C 2. Name and Addre Br	em. Marc ess of Facility ruzdzinsk	i Funera	l Home, I	ore, Maryland P.A. aryland 21221
	Physician /Medical		23a. Part the disease, or complishoo, or heart failure. List only on immediate Cause (Final disease or condition resulting in death)	/	ath. Do not en					Approximate Interval Between Onset and Death Month
760,	Examiner	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	quence of):					
P.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the tuneral director, page 2 should be detached for use as the burial-transit	Completed by Physiclan/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ yes 2 1 No 9 □ Unknown	3c. If yes, outcome of preging 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time ol g ☐ Unknown	tal death 3	Ectopic pregnancy Other (specify)	y		23d. Date of Month	
ords, P.	equires that en signed by ould be deta	ted by Ph	Part II. Other significant conditions con	tributing to death but not re	esulting in the u	inderlying cause giv	ven in Part I.		_	ute to the cause of death?
tal Reco	an: The law r lificate has be or, page 2 sh	a)	15Chemic Colific respiratory failure 25. Was case referred to medical	, ventlatir	depen	dant	26 Pings of Do	24a. Was a autop perfor 1 Yes ath (Check only or	sy prid med? dea 2 No 1	re autopsy findings available or to completion of cause of th? Yes 2 No
Division of Vital Record	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	atlon: To B	examiner? 1	ospital: 1 X Inpatient 2[28a. Date of Injury (Month, Day Year)	⊒ ER/Outpatier 28b. Time o Injury	f 28c. injui	ner: 4 ☐ Nursing I	Home 5 ☐ Resid		
Divis	oital or Attendi urs after death. srat Director: A	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spec	cify)			City or Tow	n, State)	or Rural Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier (Check only one) 1 Certifying Phys 2 Medical Exemir 29b. Signature and title ol certifier	icien: To the best of my krier: On the basis of examinand manner stated.	nowledge, deat nation and/or in	29c. Licens	se number	urred at the time, d	late and place, and 29d. Date signed (i	d due to the cause(s) Month, Day, Year)
	10		30. Name and address of person who co	mpleted cause of death (Ite	em 23a) (Type, 10 55	Print) OSHOPIC	ins Bay	view Cia	PCLE BALT	12,2004 (nore VOZ1224
	Sta Regist		31. Date liled (Month, Day, Year) MAR 1 7 2004	32. Registrar's Sign	nature &	barre			•	1-/

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month **Physician** Ruth G. Sargent 14, 2004 8:02 AM March /Medical 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Funeral 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign
Country) 1 □ M 2 🕅 F Months Days Hours Min 82 Director 257-16-3540 August 26,1921 Mississippi Usual Residence of Decedent 10a Stete 10h Counts 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or items 23s or 28s-f show treumatic event, the Modical Examiner maint be notified at 1 X Yes 2 □ No Directo Maryland Carrol1 Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 12 Carroll St. #132 21157 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Manital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 72 hours aftar 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Maryland 21215-0020 1 ☐ Yes 2 ▼ No Specify: Specify: ğ White 3 ☑ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry el Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Grocery Store 12 Butcher 17 Father's Name /First Middle | ast) 18. Mother's Name (First, Middle, Maiden Surname) Be 12 should be fi h and Mentel H Ie marked ott Godwin Ferdinand Clarke Laura Loretta permit. Peges 1 and 2 sh Depertment of Health and. Important: If them 27 ie me any injury or 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Andrew Earp / Son 12 Carroll St. #132, Westminster, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 🎇 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) March Chesapeake Crematory, Inc_{17,2004} Beltsville, MD 22. Name and Address of Facility Rapp Funeral and Cremation Services M00382 tookun am 933 Gist Ave., Silver Spring, MD 23a. Part1. Enfer the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical ARTERIOSCIEDO DO Examiner Due to (or as a consequence of): Examiner nding physician and usa as the burial-transit certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Box 68760. Physician/Medical Due to (or as a consequence of) ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown sate has been signed page 2 should be dat þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was en eutopsy The law certificate has 12 Yes 2010 1 TYPS 2 TNO of Vital To the Hospital or Attending Physician: within 24 hours aftar death.

To the Funeral Director: After this certifica completaly filled in by the funeral director; Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Deeth 28a. Dete of tnjury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, and due to the ceuse(s) and manner as steted.
2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. 29a. Certifier Medicai

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year) MAR 1 7

30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print)

1 7 2004

0523

32 Registrer's Signature

DHMH 16 Rev 6/95

29c. License number

29d. Date signed (Month, Day, Year)

		1	For Amend Item 11 per 1 State Registrar	Fit 95 291, 037 30/7029 16 10 10 10 10 10 10 10 10 10 10 10 10 10	epartment of Health and I Certificate of Death	vientai mygien Reg. N	2004 085 70	
	Physicia		1. Decedent's Name (First, Middle, Last)	tool Smith	Se		ay Yeer 3. Time of Death	
3	/Medic Examin	al -	4a. Fecility Name (If not institution, give st	reet and number)	4b. City, Town, or Location of Death		2004 1216 p	
	LXdiiiii		3811 Elkader Road	/	Baltimore Baltimore Hunder 1 Year Hunder 24 Hrs.	0 Date of Righ	Birthplece (State or Foreign	_
	Funeral Director	1	5. Social Security Number 211.24.0/28 119 Usual Residence of Decedent	7. Age (In yrs. last birth	nday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year)	929 WHEYLAND	_
	yland 10W	-	10a. State 10b. County	10c. City, Town			10d. Inside City Limits	
	e Mar	ctor	MD	BA	TIMORE	100.0	1 Mr Yes 2 □ No Ditizen of What Country?	4
	h with th	al Dire	3811 ELKADE	R ROAD	21218		U.S.A.	
036	be filed within 72 hours after death with the Maryland Hygiene. Hygiene. Ad thygiene. Ad the than "natural", or items 23e or 28e-f ahow avent, the Moulcal Examiner must be notified.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Arridowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 10 Yes 2 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer □ Yes 2 No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: BLACK	
21	- 3	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Sacapadary (0-12)		Decedent's Usual Occupation (Give kind of work done during most of wo life. DO NOT use retired) LABURER		STEEL	
and 21	should be filed within nd Mental Hygiene. marked other than imatic avent, the M	Be	17. Father's Name (First, Middle, Last)	SmHH	18. Mother's Na	ne (First, Middle, Maide DUISE J	en Sumame) TOHNSON	
Maryland	12 should h and Mer 7 la marke traumatic	2	19a Informant's Name/Relationship (Type)		Mailing Address (Street and Number or Ri	ural Route Number, City		
	permit. Pages 1 and 2 should Department of Heelth and Mer Important: If item 27 la marke any Injury or other traumatic ance.		20a. Method of Disposition 1 Burial 2 Cremation 3 R	20b. Place of cemeter	Disposition (Name of	Date 20c.	Location - City or Town, State	D
Baltimore,	permit. Pag Department Important: I any Injury o		*4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	* (e	22. Name and Address of Facility	USHIN C. F.K	NES MILLS, MARYLAND LEENE FUNCEAL HOME DE MO 21712	E
	205 e d		23a. Part 1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the death. Do n	TIUS JUNE KUND	c or respiratory arrest,	Approximate Interval Between	.500
>	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Contract (stars Let Uround	58 C/E	Onset and Death	
S.	Examiner		Sequentially list conditions,	Due to (or as a consequence	or).			
	nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of	of):			
8760,	cate be executed physicien and the burial-transit	dical Exa	that initiated events resulting in death) Last	Due to (or as a consequence	of):			
9		63	1					
.O. Box	thet the death certific led by the attending p detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 Ectopic pregnancy 5 Other (specify)		23d. Date of delivery Month Day Year	
۵.	98	by	Part II. Other significant conditions con	ntributing to death but not resulting in	n the underlying cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death?	1
of Vital Records,	e law has b	Completed				24a. Was an autopsy performed		9
/ital	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	fospital:	0.1	eath (Check only one)	Manual at agono	
of	Physic r this o	. To	Yes 2 No 27. Manner of Death	28a. Date of Injury 28b.	Time of 28c. Injury at	Home 5 Residence		
on	Attanding Physician: r death. actor: After this certifici by the funeral director.	atlon	1 □Natural 5 □ Pending 2 □ Accident investigation	3 904 U	Injury Work? 1 ☐ Yes 2 ☐ No	Sugred	& statselt	
Division	or Atta after de Diracto I in by th	Certification:	38 Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, fa building, etc. (Specify)	arm, street, factory, office	28f. Location (Street City or Town, St	t and Number or Rural Route Number, tate)	
_	To the Hospital or Attend within 24 hours after death To the Funeral Director: comptetely filled in by the	Medical Co	29a. Certifier 1 CertifyIng Phy (Check only one) 2 Medical Exam	slcian: To the best of my knowledg ner: On the basis of examination ar and manner stated.	e, death occurred at the time, date and pland/or investigation, in my opinion, death occurred.	ce, and due to the cause curred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)	
	To the Vithin 2 To the complet	Mec	29b. Signature and title of certifier	0 0	29c. License number		Date signed (Month, Dey, Year)	
	R	1) ((cs	heur)	OCME	Má	arch 11 2004	
	(N		50: 142:110 4113 423-121	ompleted cause of death (Item 23a)	(Type, Print) 111 Penn Str	eet, Baltin	more, Maryland 21203	1
	S Regis	tate trar	31. Date filed (Mogth, Day, Year)	32 Registrar's Signature	Joseph			

	1	For State Registrar	State of Mar	yland / Depa		Health and	Mental Hyg	_				
Physiciar /Medica Examine	1	1. Decedent's Name (First, Middle, La James Edwar 4a. Facility Name (If not institution, giv University of Maryla			n, or Location of Deat	2. Date of Death Month Day 4c. Cou		3. Time of Death				
Funeral Director		5. Social Security Number 6. S		In yrs. last birthday) 33 Yrs.		ar If Under 24 Hrs.	8. Date of Birti (Month, Da) Oct 14	, Year) , 1970	Birthplace (State or Forei Country) Maryland			
72 hours after death with the Maryland natural; or Itams 23s or 28s-1 show atcal Exposite court be notified at		10a. State 10b. County	10c. City, Town or Lo		ocation			10d. Inside City Lin 1 Yes 2				
23a or ust be	2	8905 Harkate Way				21133		U.S.A.				
ours after des ral', or Itams Exp. alter to	Dy rune	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced		Was Decedent of If Yes, specify C 1 ☐ Yes 2 ☐ X	of Hispanic Origin? (Suban, Mexican, Puerl No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Americen Indian, Black, White, etc. Specify: Black					
- 10	palaidino	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12) 12	ducation ade completed) 16a. Dec (Gi life) 16a. College (1-4or 5+)		DO NOT use ret	cupation ne during most of wor ired) ood Service	rking		ind of Business/Industry University Hospital			
2 should be filed within and Mental Hygiene. le marked other then aumatic event, the Mental Common	o Re C	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Mid						ly Ransome				
nd 2 shu lith and 27 is m r traum	i	19a. Informant's Name/Relationship (Beverly Ransome Mo	**			e Way Randall			State, Zip Code)			
permit. Pages 1 and 2 Department of Health a Important: if Itam 27 Is eny Injury or other trai once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specif			osition (Name of matory or other p tus Memoria	olace)	Date 03/13/04		City or Town, State altimore , Md			
permit. Departr Imports eny Inj		21. Signature of Fune al Service Licer	neval Service Licensee 22. Name and Address of Facility Estep Brothers Funeral Home P.A 1300 Eutaw Place Baltimore, MD									
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		Part II. Other significant conditions of	contributing to death but r	not resulting in the u	inderlying cause	given in Part I.	23e. Did to		use contribute to the cause of death?			
The law req	Completed						24a. Was a autop perfor 1 □ Yes	sy p med? d	Vere autopsy findings availal rior to completion of cause c leath? □ Yes 2 □ No			
Physicien: The this certificate ral director, pag	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	2 ER/Outpatier	nt 3 DOA	Othor	th (Check only or		1 (Citi)			
tending Physicater. Seath. tor: After this compared fine funeral directions.	Certification: 1	27. Manner of Death 1. Natural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not b	28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1						ed			
	edicai cerm	4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Physician: To the best of my knowledge, death occurred at the time, date and place, xaminer: On the basis of examination and/or investigation, in my opinion, death occur					28f. Location (Street and Number or Rural Route Number, City or Town, State) ,, and due to the cause(s) and manner as stated.				
To the h within 24 To the F complete	Мед	29b. Signature and title of certifier 29d. Da P17708 Ma							Date signed (Month, Day, Year)			
D		University of Mar	yland Medi	ical cente	22 S	. Greene St	Baltin	nore, MI	ZIZOI			
State Registra		31. Date filed (Menth Day, Year)	32 Registrar's	s Signature	made 1							

		4	For State Registrar	State of M	Marylar	nd / Depa <i>Cei</i>	artment of H	lealth a	and Mental H	ygier Reg. 1	1e2004	085	572
			Negistrar 1. Decedent's Name (First, Middle, Last)					2. Date of Death				3. Time of	f Death
	Physicia		Stanley Simpson	Month February				3, 2004	9:54	ΡМ			
	/Medic Examin		4a. Facility Name (If not institution, give		4b. City, Town, or Location of Death				c. County of Death	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
		•	Washington Advent:					Montgomery					
	Funeral		5. Social Security Number 6. Se	If Under 1 Year If Under 24 Hrs. 8. Date of Birth				9. Birthplace (State or Foreign					
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	DC *	by Funeral Director	Usual Residence of Decedent 10a. State 10b. County		10c Cit	ty, Town or Lo	cation				1	0d. Inside C	in I invite
	sho		Maryland Prince Go	eorge		ttsvil							2 □ No
	the M		10e. Street and Number		11)		10f, Zip Code			100 (Citizen of What Coun		
	with		6500 Riggs Road				20783				U.S.A.	try r	
	ns 23		11. Marital Status	12. Was Decede	nt Ever in U	.S. 13 V		tispanic Ori	gin? (Specify Yes or I	No-	14. Race - Americ	an Indian	
	fter d	Fun	1 Never Married 2 Married	Armed Force	s?		f Yes, specify Cub	an, Mexicar	gin? (Specify Yes or I n, Puerto Rican, etc.)	••	Black, White,		
ğ	urs a	þ	1 ☐ Never Married 2 ☐ Married 1 第 Never Married 2 ☐ Married 1 第 No If \$\mathbb{Y}\$ Pss. \$\mathbb{G}\$ ive \$\mathbb{G}\$ ive \$\mathbb{Y}\$ Pss. \$\mathbb{G}\$ ive \$\mathbb{Y}\$ Pss. \$\mathbb{G}\$ ive \$\mathbb{Y}\$ Pss. \$\mathbb{G}\$ ive \$\mathbb{Y}\$ Pss. \$\mathbb{G}\$ ive				1 ☐ Yes 21 No Specify:				Specify: White		
Ō	within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28e-f show he Medical Examiner must be notified at	Completed	15. Decedent's Ed	ucation		16a. Deced	dent's Usual Occup	ation	t of we drie o	16b.	Kind of Business/Inc		
2	thin 7		(Specify only highest grade Elementary/Secondary (0-12)	College (1-4c	or 5+)	life. L	kind of work done OO NOT use retire	d) mos	t or working				
2	ed wi		12			Unav	vailable			Uı	navailable	:	
ם	be fill d oth	Be	17. Father's Name (First, Middle, Last)					18. Mothe	er's Name (First, Midd	le, Maide	en Sumame)		
<u> </u>	Men Men arke	To	Unavailable					ł.	mavailable				
Jar	2 sh and is m		19a. Informant's Name/Relationship (7						er or Rural Route Num			Code)	
o î	l and lealth im 27 her t		Teresa Dimka/Guaro	lian	20h F				., Crofton	-			
0	ges it of the state of or ot		20a. Method of Disposition Y□ Burial 2 □ Cremation 3 □		10		sition (Name of natory or other pla	1	3-16-2004		Location - City or To		
Baltimore, Maryland 21215-0036	t. Pa rtmer rtant: njury		*4 □Donation 5 □Other (Specify		Mar		Veteran			Che	ltenham, 1	Maryla	ınd
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itams 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.		21. Signature of Fuheral Service Licensee 22. Name and Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Rd., Brentwood, MD 20722										
П			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between										
,	Physician		Immediate Cause (Finat disease or condition	549	TEM	10 8	PRSIC	10/197	+ shock	,		Onset and I	Death
/Medical Examiner			resulting in death)	Due to (or	as a conseq	uence of):			11000			la	and the same of th
	e .	dical Examiner	Sequentially list conditions,	b. RES	SPIRATORY FAILURE as a consequence of):						1 d	ay	
	be sit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	(or as a consequence of): EM EW TA							ı		
_	and and II-trar		that initiated events resulting in death) Last					years					
8760,	icate be executed physician and s the burial-transit												
687	ficate phys s the	g		d									
Box	death certifica attending ph d for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant					23d. Date of delivery Month Day Year					
m	death e atte d for	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time of death 5 Other							ctopic pregnancy Other (specify)		
О	that the de led by the a detached t	hysi	9 Unknown										
'n.	res tha iigned be det	by P								use contribute to the	contribute to the cause of death?		
ğ	w require been sig should b		1 Tes] Yes	2 No 3 Probably 4 Unknown		
Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due								24a.\			24b. Were autop		
The lave from the law page 2 composition of the law page 3 composi									autopsy performed? prior to completion of cause death? Yes 2 No 1 Yes 2 No			AUSO OI	
ta	iclan: Th certificate rector, pag	Bec	25. Was case referred to medical examiner?					26. Place	of Death (Check only		(0)		
>	Physic this ce al dire	2	1 ☐ Yes 2 No	Hospital: 1 Kinpa	atient 2 🗆	ER/Outpatien	t 3 DOA Oth	ier: 4 □ Nu	rsing Home 5 Re	sidence	6 Other (Specify)	
0	ding Pl h. After ti tunera		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Ir (Month, I	njury Da <i>y Year)</i>	28b. Time of Injury	28c. injur Wor	y at k?	28d. Describe	how inj	ury occurred		
Sio	tendi eath. tor: A the tu	catl	2 Accident investigation 3 Suicide 6 Could not be					Yes 2□!	No				
\leq	il or Attending Physician: after death. Director: After this certifica in by the tuneral director, i	Certification:	4 Homicide determined	eet, factory, office 28f. Location (Stre City or Town,				et and Number or Rural Route Number, State)					
	pital urs a eral [
	To the Hospital or Attending Physiclan: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the tuneral director, page	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
								29d. Date signed (Month, Day, Year)					
	_		Miss	note				-178	374	,	2/15/04		
	8	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S-M-NAYAR MD 3717-38" ANE COTTAGE CITY MD 2072.2 tate 31. Date filed (Month Par Year) 7 2004 32. Redistrar's Signature.											
			S-M-NAYAR M	000 A 32 PM	1-3	atural d	marks I	uo C	-117 /	40	20122		
	Sta Registr		31. Date filed (Month PARYer) 7	2004	strar's Signa	10. P							

Physician /Medical Examiner	Registrar 1. Decedent's Name (First, Middle, Last		Certificate of Death	Reg. No.	004 0857
/Medical	I. Douddelle Hallo (First, Middle, Last)		2. Date of Death Month Day	3. Time of Death
`	Altha D.	Stewart		3 13	07 10:55 P
Examiner	4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of Deal		unty of Death
	Subushen Ho	spital	Bethanda,	Mo No	atsomery.
Funeral	5. Social Security Number 6. Se	x 7. Age (In yrs. last birtl	hday) If Under 1 Year If Under 24 Hrs Months Days Hours Min		Birthplace (State or Fore Country)
Director	579-34-1655	JM 2/10 F 74 Y	rs. Northis Days	June 30, 192	9 Florida
D	Usual Residence of Decedent	140 00 7			10d. Inside City Lim
ylan how	10a. State 10b. County	10c. City, Town	or Location		1) Yes 2
a-f s	Maryland Montgome	ry Gaith	ersburg		
or 28a-f sl	10e. Street and Number		10f. Zip Code		of What Country?
th wi	419 Russell Avenu	.e #505	20877	US.	
fier death virtems 23st liner must	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	Specify Yes or No-	Race - American Indian, Black, White, etc.
afte of T	1 Never Married 2 Married	1 ☐ Yes 2 █ No If Yes, Give	1 ☐ Yes 2 No Specify:		ecity: white.
Marylatina Z. I.Z. 13-0030 nd 2 should be filed within 72 hours att the and Marhal Hyghens 27 is marked other than "natural; or "traumatic svent, the Marclest Exercit To Be Completed by F	3 Widowed 4 Divorced	Year or Dates:	D	16h Kind	of Business/Industry
ed within 72 houygiene. ser than "naturalit, the Mudical E	15. Decedent's Ed (Specify only highest grad	de completed)	Decedent's Usual Occupation (Give kind of work done during most of wo life. DO NOT use retired)	orking 165. Kind 6	or Business/industry
m Pan G	Elementary/Secondary (0-12)	College (1-4or 5+)			tel/Motel
Co Co	12 17. Father's Name (First, Middle, Last)		Secretary 18. Mother's Na	me (First, Middle, Maiden Sur	
should be filed within 72 hours after death with the Maryland and Mental Hygiene. In matural; or items 23a or 28a-f show umatic svent, the Madical Examiner mats be notified at To Be Completed by Funeral Director		41		e Brooks	
ould Men	James Herbert Br		Mailing Address (Street and Number or R		own State Zin Code)
2 sh and Is m	19a. Informant's Name/Relationship (7 William Stewart -		Russell Avenue #50		
and and m 27 m 27 her t			Disposition (Name of		ion - City or Town, State
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mentall Hygiene. Department of Health and Mentall Hygiene. To Be Completed by Funeral Director	20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐	Removal from State cemeter	y, crematory or other place)		
Pag men ient:	*4 □Donation 5 □Other (Specify	100	Lincoln Crematory 3	/18/2004 Bren	twood, MD
Dermit. Depart Import	21. Signature of Funeral Service Licen		22. Name and Address of Facility F		
30553	Mydlin T. Webert	MO1322	3401 Bladensburg		
	23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused the death. Do not cause on each line.	not enter the mode of dying, such as cardia	ac or respiratory arrest,	Approximate Interval Between Onset and Deat
Physician	Immediate Cause (Final disease or condition	Acidosis			0,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
7Medical	resulting in death)	Due to (or as a consequence	of):		
Examiner	Conventially list conditions	h Hypoxemia			12 495
le l	Sequentially list conditions, it is a line to made cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of	of):		
cate be executed physician and site burial-transit cate be axacuted physician and site burial-transit categories.	Cause (Disease or injury that initiated events	c. Sa Sa S			12 40.
exe exec	resulting in death) Last	Due to (*r as a consequence	of):		N.
cate be exphysician the buria		. d			
tiffica ng ph as th					
The taw requires that the death certific the has been signed by the attending page 2 should be detached for use as completed by Physiclan/Mec.	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death	3 Ectopic pregnancy	23d	Date of delivery Month Day Year
death	in the past 12 months? 1 ☐ Yes 2 🖺 No	4☐ Pregnant at time of death 9☐ Unknown	5 Other (specify)		World Day Four
that the de detached detached	9 Unknown				
S, T es that igned be de	Part II. Other significant conditions of	7 A 1	and the second s		contribute to the cause of death
law requires that seem signed as should be a	celcinoma	et the lung	stge HA	1 Li Yes 2 KUN	lo 3 ☐ Probably 4 ☐Unki
The law requir cate has been si page 2 should				24a. Was an 2 autopsy	24b. Were autopsy findings ava- prior to completion of cause
he tar he tas e has age 2				performed?	death? 1 ☐ Yes 2 🗷 No
			26. Place of De	eath (Check only one)	
Physicien: this certific ral director.	examiner?	Hospital:		Home 5 Residence 6 □	Other (Specify)
9 g = E E E	10.0	28a. Date of Injury 28b.	Time of 28c. Injury at	28d. Describe how injury o	
ding ding h. After funer	1 🔀 Natural 5 □ Pending 2 □ Accident investigation		njury Work? M 1 Yes 2 No		
ISIO kitendi death ctor: A y the fi	3 Suicide 6 Could not be	28e. Place of Injury - At home, fa building, etc. (Specify)	irm, street, factory, office	28f. Location (Street and N	lumber or Rural Route Number
	4 Homicide	building, etc. (Specify)		City or Town, State)	
Oivi		sysicien: To the best of my knowledge	e, death occurred at the time, date and place	ce, and due to the cause(s) an	d manner as stated.
DIVISION C pital or Attending P ours after death. lerel Director: After i filled in by the funeral	(Check only 2 Medicel Exar	niner: On the basis of examination an and manner stated.	nd/or investigation, in my opinion, death oc	curred at the time, date and pla	ace, and due to the cause(s)
Hospital or Al 24 hours after of Funeral Direction by the property of the prop	one)		29c. License number	29d. Date s	igned (Month, Day, Year)
by INTENDIAL of the Hospital or Attending thin 24 hours after death. to the Funerel Director: After implietely filled in by the fune Madical Certification	29b. Signature and title of certain				
To the Hospi within 24 hour To the Funer completely fill	one) 29b. Signature and title of certifier	4. ^	10 -00/1		3/15/04.
To the Hospital or Al within 24 hours after of To the Funeral Direct completely filled in by Madical Certif)	Y.D.	40 59867		3/15/04.
To the Hospi within 24 hour To the Funer completely fill	29b. Signature and title of certifier 30. Name and address of person who	completed cause of death (Item 23a)		soll Aur.	3/15/04. Takone lok 2

			1 - For Stata Registrar			of Ma	arylar		artmen rtificat				1ental Hy	Reg. N	200) L ₄	08574
	Physici	an	Decedent's Name (First, Mich.										2. Date of De Month	D		Year	3. Time of Death
	/Media	cal	Frances Lena 4a. Facility Name (If not institut			number)			4h City	Town or	Location	of Dooth	March		200 c. County o		9:40am ^M
	Examir	ier	100 Susquehar						,		e Gr				Harfo		
	Funeral		5. Social Security Number	6. Sex	x	7. Age	(In yrs.	last birthday)	If Under	1 Year	If Under	24 Hrs.	8. Date of Bi				place (State or Foreign
	Director		212-28-6756	1]м 2 Х О́́́		71	Yrs.	Months	Days	Hours	Min.	8. Date of Bi (Month, D 09 / 15 /	193	ź I	Penr	nsylvania
	and		Usual Residence of Decedent 10a. State 10b. Cour	ity			10c. Cit	ty, Town or Lo	ocation							1	I0d. Inside City Limits
	Maryl f sho	ō	MD Har	ford			H:	avre d	e Gra	200		,					1X Yes 2 □ No
	r 28a	rec	10e. Street and Number	101 0			110	avie d	10f. Zip					10g. C	itizen of Wi	nat Cour	ntry?
	th wit	a D	100 Susquehan	na (Court				2	1078					JSA		
	r dea	Funeral Director	11. Marital Status			Forces?		.S. 13.	Was Deced	lent of Hi	spanic Or n, Mexica	igin? (Sp n, Puerto	ecify Yes or No Rican, etc.)	0-		- Amenic	ean Indian, etc.
36	s afte	by Fi	1 ☐ Never Married 2 ☐ M 3 🛣 Widowed 4 ☐ Divorc		1 □Ye	s 2 X N Give or Dates:	lo		1 🗆 Yes		Specify:				Specify:		
21215-0036	within 72 hours after death with the Maryland ane. than "natural", or items 23a or 28a-f show ha Mudical Examinar must be notified at	ed	15. Deced	ent's Edu	cation			16a. Dece	dent's Usua	I Occupa	ation			16b.	Kind of Bus		dustry
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	filed wit Hygiene other the	l S	11th				.,	Hom	emake	er					Home		
nd	be filed tal Hygi d other	Be	17. Father's Name (First, Middle	e, Last)							18. Moth	er's Name	e (First, Middle	, Maide	n Sumame,)	
yla	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, Its M.	ဥ	Frederick Sco		0.2.0			401 14 11					. Bulet				
Maryland	d2st than than 71sn traun		19a. Informant's Name/Relatio Betty Stanyare			tor							al Route Numb Havre	-			
	tem 27 tem 27 other tr		20a. Method of Disposition	u D	augn	rei	20b. F	Place of Dispo	sition (Nan	ne of			Date		Location - C	-	
ē	Pages nert of int: if its		1 X Burial 2 ☐ Crematio 4 ☐ Donation 5 ☐ Other		lemoval fro	om State		cemetery, crea rford 1				N3 / 19	R/OU		erdeer	-	
Baltimore,	그 등 원 등		21. Signature of Funeral Service		99		IIIai										
ä	Depa Impo any ir		Julaine	~). E	mi	SH	12	litche 3 S.	II-Sr Wasi	nith hinat	Fune	eral Ho Havre	me, de	Grace	. M	D 21078
			art1. Enter the disease, shock, or heart failure. L	or compli	ications the	at caused in each lin	the deat	h. Do not ent	er the mode	of dying	, such as	cardiac o	or respiratory a	rrest,			Approximate Interval Between
3	Physician		Immediate Cause (Final disease or condition		M	eta	sla	lec	Ce	٧٠٠	ica	0	Call	Con			Onset and Death
	/Medical Examiner		resulting in death)		Due	to (or as a	conseq	uence of):									
	Examine:	7	Sequentially list conditions,	t)	to (or as a	conseq	uence of):									
	rted	n in	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	≺	540	10 (01 43 6	CONSEQ	derice ory.									
Ć,	execu n and ial-tra	Examiner	that initiated events resulting in death) Last	· ·	Due	to (or as a	conseq	uence of):				•				_	
8760,	cate be executed physician and s the burial-transit	ical		L.	d												
9		Jedi	IF FEMALE:	-													
Вох	eath certif attending for use as	Physician/Med	23b. Was decedent pregnant in the past 12 months?	2		e birth	2 Feta	I death 3	Ectopic pre	gnancy					23d. Date		ry Day Year
0.	the a	sic	1 ☐ Yes 2 ⊠No 9 ☐ Unknown			egnant at i	time of d	leath 5□	Other (spe	ecify)					WOIL		Day 10a
Δ.	es that lhe d gned by the be detached		Part II. Other significant cond	tions cor	ntributing to	death bu	t not res	ulting in the u	nderlying ca	use give	n in Part I		23e. Did t	obacco	use contrib	ute to th	e cause of death?
Vital Records,	uires sign id be	d by							, ,								ably 4 □Unknown
Ö	w requir been si should	Completed											24a. Was	an	24b. We	re auto	osy findings available
Re	The lav	mo di		-									auto	psy prmed?	prid dea	or to cor ath?	npletion of cause of
tal	sician: The certificate hi	0	25. Was case referred to medi-	cal							26. Place	of Death	1 ☐ Yes	2'⊠N one)	0 1 1	Yes	2 No
>	ysici nis cer direc	ToB	examiner? 1 ☐ Yes 2至No	Н	lospital:	☐ Inpatier	nt 2 🗆	ER/Outpatier	t 3 DO	A Othe	~		ne 5 ENGesi		6 □Other	(Specify	')
n of	Attending Physician: r death. ector: After this certifics by the funeral director, I		27. Manner of Death 1.≅Natural 5 ☐ Pend	dina	28a. Da (M	ite of Injur Ionth, Day	Year)	28b. Time of Injury	28	Bc. Injury Work	at ?	:	28d. Describe	how inju	ry occurred		
Division	• Attendi er death. rector: A by the fu	Certification:		stigation					М		′es 2 🗆						
Ξ		it.		rmined	28e. Pla	ilding, etc	ry - At ho . (Specify	ome, farm, str	eet, factory,	, office		1	28f. Location (. City or Tou	Street a wn, Stat	nd Number 'e)	or Rura	l Route Number,
_	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director:		29a. Certifier 1 Certify	ing Phvs	ician: To	the best o	f my kno	wiedge, deati	occurred a	it the time	e, date an	d place :	and due to the	Called/	and mann	eras et	ated
	e Hos	Medical	(Check only 2 Medic	al Examia	ner: On the	a basis of anner stat	examina	tion and/or in	estigation,	in my op	inion, dea	th occurr	ed at the time,	date an	d place, and	d due to	the cause(s)
	To the Hospita within 24 hours To the Funeral completely filled	Me	29b. Signature and title of centr	ier		1			29c.	License	number			29d. Da	ate signed (Month, l	Day, Year)
	0		Veren	L	9	De	-	- MI) 1	D 3	30	99		31	1610	4	
	dh)		30. Name and address of person	n who co	mpleted 6	ause of de	ath (Iten	1				_				1	2100 /
		25	TROMILA S	URI		153	- u	HI	911	STI	REE	T,	ELKT	01	1	D	2192/
	Sta Registr		31. Date filed (Month, Cay Ye	7 20)04	. Registra	rs Signa	J. A	nouse	,							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2004 08575

4.1.9		Registrar				_	or timou		Death	1		Reg. No	•		
	100	Decedent's Name	(First, Middle, L	Last)							2. Date of De	aath Dav	y	Year	3. Time of Death
Physician /Medical	_	IRENE		MAE	S	LEEMAN					Marrel		21	104	7;45H,
Examiner	4	Facility Name (If I	not institution, g	ive street and	number)		ab. City	y, Town, or	r Location	of Death		46.	County o	f Death	undei
			rundel '	HOSPIT	-	un fact hintha	CHE 1	er 1 Year	If Unde	r 24 Hrs.	8 Date of Bi	Th M	nhe	9 Right	Jace (State or Foreign
eral ctor		Social Security Nui 214-24-291		.Sex 1□M 2 XX F		rs. last birtho Yrs	Months		Hours		8. Date of Bi (Month, Di JUNE 8,	1920		MARY	ilace (State or Foreig htry) LAND
	-	sual Residence of D													Od Jasida City Limit
other traumatic event, the Maulcal Examiner must be notified at To Be Completed by Funeral Director		a. State	10b. County		10c.	City, Town o								'	0d. Inside City Limit:
Director	M	ARYLAND				BALTI	MORE CI					10a Cit	izen of W	hat Cour	
Dire	10	e. Street and Num					101. 2	ip Code 2123				•	S.A.	nat Cour	iuy:
ara .	3	. Marital Status	TICOKE SI		ecedent Ever in	n U.S.	13. Was Deci			rigin? (Sp	ecify Yes or N			- Americ	can Indian,
by Funeral	, i	1 ☐ Never Marrie		Armed 1 ☐ Ye If Yes.	Forces?		_	ecify Cuba 2 XX Vo			ecify Yes or N Rican, etc.)		Specify:	, White,	etc. ITE
ted t		/Specif	15. Decedent's fy only highest	Education	ad)	16a. D	ecedent's Us	ual Occup	ation	ast of work	rina	16b. K	ind of Bus	siness/In	dustry
Completed	-	Elementary/Secon			e (1-4or 5+)		Give kind of w ife. DO NOT		d)		9		OWN	HOME	
O D	5	8				HO	MEMAKER	!			- (C) 10 0 d d	14-7-4		HOME	
8	ง ¹⁷	7. Father's Name (F	_							DA	e (First, Middle MAE	BURY		*)	
۲		WILLIAM	A	BELL Trans Small		10b A	Asifna Addro	ss (Stroot	<u> </u>		al Route Numi			State Zir	Code)
	1	9a. Informant's Nai			-									71010, Zip	, 0000)
	20	JUNE MARIE		- DAUGHIE	R 20	b. Place of D	Disposition (N.	lame of			MARYLAN Date			City or To	own, State
5	-	1 Degurial 2	Cremation 3	B □Removal fro	om State		of FAIT			МАРСН	15, 2004	RA	LTIMO	RF M	ARYLAND
any injury or of	2	4 □Donation 1. Signature of Fur			2.0	ARDENS	22. Name a				FINK FL	_	72.7.7.7		
once		VENE	Y LRECORY	20111	101148	_/	426 CR	AIN HI	I CHWAY	s., (CLEN BURN			-	061
, wh	2	23a. Part1. Enter th shock, or hear	ne disease, or co	omplications th		lasth Dono									Approximate
an					an anah lina	eath. Do no	t enter the mo	ode or dyli	ig, sacira	is cardiac	or respiratory	arrest,			Interval Between
an	[1	mmediate Cause (f	Final	nly one cause o	on each line.	eath. Do no	t enter the mo	ode or dyli	ng, 30011 a	is cardiac	or respiratory	a1163t,			Interval Between Onset and Death
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DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 2004 08576 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician IARC SMITH ROI AND /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGES SOUTHERN MARYLAND HOSPITAL CENTER CLINTON If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) 6. Sex 5. Social Security Number **Funeral XX**M 2□ F FEB 10, 1931 FLORENCE, 248-32-9573 73 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits with the Maryland 10a. State 10b. County r than "natural", or Itams 23a or 28a-f show the Wedteal Examiner must be notified at tx Yes 2 □ No Directo MARYLAND PRINCE GEORGES CLINTON 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20613 U.S.A. 9211 STUART LANE death v Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 101 Yes 2 □ No If Yes, Give Year or Dates: 11. Marital Status hours after 1 Never Married 200 Married 0 1 Yes 2 No Specify: Specify: BLACK þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 72 within I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) TRUCK DRIVER TRANSPORTATION is 1 and 2 should be filed in Health and Mental Hygie Item 27 is marked other tother traumatic event, the 11 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be **ROCEDA** ROLAND SMITH F7FK LFL ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3018 ST. MIHIEL AVENUE, NORFOLK, VIRGINIA 23509 JERRY SMITH other 1 permit. Pages 1 and Department of Healt Important: If item 2 any injury or other once. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1XX Burial 2 Cremation 3XX Removal from State U.S. NATIONAL CEMETERY 3/18/2004 FLORENCE, SC 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FINK FUNERAL HOME, PA CRECORY FINK #M01148 426 CRAIN HIGHWAY S., GLEN BURNIE, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Supsis Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner spiratory Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a consequence of): Examiner Snorch 4 tute burial-tran Due to (or as a consequence of): the attending physician strolce Physician/Medical the as nse IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Live birth Day Month Year in the past 12 months? ģ 4☐Pregnant at time of death 5 Other (specify) o 9 Unknown þ 0 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Records, pe ple stroke associated deventia 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed peen 24b. Were autopsy findings available prior to completion of cause of death? pertension 24a. Was an has page 2 autopsy performed 2 No certificate 1 ☐ Yes 2.K No 1 Yes Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 EP/Outpatient 3 DOA ၉ ō this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After 5 Pending Division 1 Natural 1 ☐ Yes 2 ☐ No death. investigation lospital or Attendi I hours after death. uneral Director: A 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide thin 24 hours at the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 20053219 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) office ROAD, WALDORF, MD A. ANSARIMO TE POST 32. Registrar's Signature Day, Year) State 17 2004 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** Tipton March 16, 2004 4:16 am Jack /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Gilchrist Center for Hospice Towson Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 12/14/1929 5. Social Security Number 6. Sex 1X M 2 ☐ F Birthplace (State or Foreign Country) **Funeral** Director 410-44-8888 74 Tennessee Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show event, the Medical Exercand must be notified at 1 ☐ Yes 2X No Directo Middle River Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12 "E" Starwood Court by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1∑1 Yes 2 ☐ No If Yes, Give Year or Dates: Korean Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married ō Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced "naturel" White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, ILA Misons. Elementary/Secondary (0-12) College (1-4or 5+) Automobile 12 Forklift Operator Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ပ James Blaine Tipton Julia Ann Miller 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cometery, crematory or other place) Kimberly Kordon (Daughter) Perry Hall, Maryland 21128 Saltimore, Date 20a. Method of Disposition 20c. Location - City or Town, State 3/20 2004 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Tipton Family Cemetery Roan Mountain, TN 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex, Maryland 21221 23a. Part1. Enter the disease, or-complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician car /Medical Due to (or as a considence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last Due to (or as a consequence of) Examiner anding physician and use as the burial-transit Due to (or as a consequence of): Physician/Medical Box IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by cate has been sig 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 No Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After 1 Natural Injury 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of a rtifler 29c. License number 225205 march 16, 2004 30. Name and address of person who completed cause of death (IMITI 23a) (Type, Print) (Type. Print) N. Charles St. Balto. md 2(20) W. A-Riley 6201 63mc 32. Registrar's Signature 31. Date filed (Month, Day, Year) MAR 1 7 2004 Registrar

			For State Registrar	State of	Marylan	d / Depa <i>Cer</i>	artment of H tificate of L	ealth and N Death	⁄lental Hygi Re	ene 20	04 085	78
i	Physici		Decedent's Name (First, Middle Leon Thompson						2. Date of Death Month March	Day 2004	3. Time of Dear	
to the	/Medio Examir		4a. Facility Name (If not institution 2702 Keyworth	n, give street and num. Avenue, Ap	ber) ot 301			Location of Death Baltimor		4c. County of N/A	1	
	Funeral Director		5. Social Security Number 213-26-7979	6. Sex 7 1 ★ M 2 ☐ F	. Age (In yrs.	last birthday) 79 _{Yrs.}	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Jan 20,	Year) 1925	Birthplace (State or Fo Country) SC	oreign
	Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County MD N/A			y, Town or Lo					10d. Inside City L	
	3a or 28a	Il Director	10e. Street and Number 2702 Keyworth	Avenue, Ap	t 301		10f. Zip Code 21215		10	g. Citizen of Wha	•	
926	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "naturel", or items 23a or 28a-1 show surmatic event, the Medical Exprairter must be realitied at	by Funeral	11. Maritat Status 1 Never Married 2 Mari 3 Widowed 4 Divorced	12. Was Deced Armed Ford 1 Yes 2 If Yes, Give Year or Da	No No	1	Was Decedent of Hi f Yes, specify Cuba 1 Yes 2 No	spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)		American Indian, White, etc.	
Maryland 21215-0036	filed within 72 how Hygiene. wher than "nature ent, the Medical E	Completed	15. Deceden (Specify only higher Elementary/Secondary (0-12)	t's Education st grade completed) College (1-	4or 5+)	(Give	dent's Usual Occupa kind of work done o DO NOT use retired er	luring most of worl	rina	6b. Kind of Busin Resident	ess/Industry	
yland 2	should be filed and Mental Hygi marked other urmatic event, I	To Be Co	17. Father's Name (First, Middle, Haywood Thom	Last) OSON, Sr.		1			e (First, Middle, M Hendersor	,		
, Man	and 2 sho salth and 5.27 is mu er trauma		19a. Informant's Name/Relations Mrs. Alice Tho			2702	g Address <i>(Street a</i> Keyworth					
altimore,	permit. Pages 1 and 2 should by Department of Health and Menta Important: If item 27 is marked any injury or other traumatic a <u>once</u> .		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 1 ☐ Donation 5 ☐ Other (S		tate C	hesapea	sition (Name of natory or other place ake Crema	tory	Mar 17 2004	Oc. Location - Cit Beltsvil	le, MD	
Balt	permit. Depart Import any inj		21. Signature of Funeral Service	Licensee	900M	86 22	Name and Address Cremation 8717 Gree	s of Facility 1 and Fun en Pastur	eral Alt es Drive	ernative Baltim	s ore, MD	
	Physician /Medical Examiner		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	only one cause on ea	used the death ch line.	CA	er the mode of dying		or respiratory arre	st,	Approximate Interval Between Onset and Deat 3 M 0 N 7	ith
8760,		dical Examiner	Sequentially list conditions, if any, leading to introducte cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	С.	r as a consequ							
O. Box 68	it the death certificate be executed by the attending physicien and tached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		th 2 ☐ Fetal nt at time of de	Ideath 3	Ectopic pregnancy Other (specify)			23d. Date o Month	delivery Day Year	r
rds, P.	quires that t n signed by uld be deta	by	Part II. Other significant condition	ons contributing to dea	ath but not resi	ulting in the ur	nderlying cause give	on in Part I.			te to the cause of death	- 1
Il Records,	: The law requires that cate has been signed b page 2 should be deta	Completed							24a. Was an autopsy perform	24b. Wer prior deat XNo 1 🗆		ilable e of
t Vital	nysician: Th nis certificate director, pag	To Be	25. Was case referred to medica examiner? 1 ☐ Yes 2 № No	Hospital:	patient 2	ER/Outpatien	t 3 DOA Othe	·C	h (Check only one		Specify)	
Division of	or Attanding Physician: atter death. Director: After this certific in by the tuneral director,	Certification:	27. Manner of Death 1 Matural 5 Pendir 2 Accident investi	gation	Injury , Day Year)	28b. Time of Injury	Work		28d. Describe how			
Š	pital or Att ours after d laral Direct tilled in by i		3 Suicide 6 Could 4 Homicide determ	ined 200. Fiace C building	g, etc. (Specif)	v) 	eet, factory, office		City or Town,	State)	r Rural Route Number,	
	To the Hospital o within 24 hours at To the Funeral D completely tilled it	Medical	(Check only 2 Medical one)	g Physician: To the b Examiner: On the bas and manne	sis of examina	wledge, death tion and/or inv	estigation, in my op	inion, death occur	red at the time, dai	e and place, and	due to the cause(s)	
,	viti To	-	29b. Signature and title of certifie	- Ann			29c. License	1071		d. Date signed (M		
	B		30. Name and address of person RANANDA K	who completed cause		23a) (Type, I			BALT	MOR	E MS 21	1201
	Sta Registr		31. Date filed (Month, Pay, Year)	7 2004 32. Pe	gistrar's Signa		andis					

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	Physici		1. Decedent's Name (First, Middle, L Bertha								2. Date of Dea Month	th	Čear O V	3. Time of Death
-	/Medi Examir		4e. Facility Neme (If not institution, g				4b. City, 7	Town, or	Location of		altimore	4c. County		N/A
	Funeral Director		5. Social Security Number 6. 213-32-5342 Usuel Residence of Decedent	Sex 7. 1 □ M 2 □ FX	Age (In yrs. la	st birthday) 68 Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day	7, 1936		ace (State or Foreign ry) Maryland
	Maryland e-f show	ctor	10a. State 10b. County Maryland	Howard	10c. City,	Town or Lo	cation		Columb	oia			10	od. Inside City Limits
	th with the 23a or 28	al Director	10e. Street and Number 6583 Overheart Lar	ie			10f. Zip	Code	21	045	1	0g. Citizen of \	What Count	•
9036	be filed within 72 hours after death with the Maryland stal Hygiene. Id other than "natural", or Itame 23a or 28e-f show event, the Mudical Examinar must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Dix	12. Was Decede Armed Force 1 Tes 2 If Yes, Give Year or Date	∍s? □No X	1	Was Decedor f Yes, special	rfy Cubar	n, Mexican,	in? (Spe Puerto	ecify Yes or No- Rican, etc.)		e - America ck, White, e	
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, Man	5 = 2 ±		19a. Informant's Name/Relationship Sharon Turner Dau				6583 O	verhe			^{I Route Number} mbia, Mary			Code)
imore	Pa Int		20a. Method of Disposition 1 □ Berial 2 □ Cremation 3 1 □ Donation 5 □ Other (Spec		ite Cer	ice of Dispo metery, cren Maryland	natory or oti	her place	1		03/17/04	20c. Location -	City or Tow	
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8760,	Physician /Medical Examiner sthe prival-transit	dical Examiner	23a. Part1. Enter the disease, or co shock, or heaf failure. List onl Immediate Cause (Finat disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or b. Due to (or c.	as a conseque	Identification of the second o	1 My	Second Se	who is considered to the second secon	ardiac o	r respiratory dri	est,		Approximate interval Between Onset and Death
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Records, P	w requires that been signed t should be det	ed by P	Part II. Other significant conditions	contributing to death	h but not result	ting in the ur	nderlying ca	use giver	in Part I.		23e. Did tob	V	ibute to the	cause of death?
	iician: The law ra certificate has be rector, page 2 sha	Completed by	, 								24a. Was an autops perform	ned?	rior to comp eath?	sy findings available pletion of cause of
Division of Vital	ding Phys n. After this funeral di	atlon: To Be	25. Was case referred to medical examiner? 1 Yes No 27. Manner of _eath 1 Natural			R/Outpatient 8b. Time of tnjury		Other c. Injury : Work?	4 □ Nurs	sing Horr	Check only one ne 5 Peside Reside Red. Describe ho	nce 6 Othe		
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	To the Hospital within 24 hours a to the Funeral I c mpletely filled	Medical (29a. Certifier (Check only one) 1 Certifying P 2 Medical Exa	thysician: To the be iminer: On the basis and manner	s of examinatio	ledge, death on and/or inv	estigation, i	in my opi	nion, death	place, a occurre	d at the time, da	ite and place, a	nd due to th	ne cause(s)
1			· Myson	WG V	of death (Item 2	W (Type 5	DD	License	195	8	N	d. Date signed	I Q	2004
	Sta	te	30. Name and address of person who are all the state of t	11015	2 (M strar's Signatu	re	_	NM	IW	2.00	slum	BIH A	ΔA	21045
	Registr		wirth T	1004	Color &	de	acts,							

State of Maryland / Department of Health and Mental Hygiene 2 08580 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March Year Physician CHARLES B. TEMPLEMAN /Medical 200 4a. Facility Name (If not institution, give street and number) 4b. City, Fown, or Location of Death 4c. County of Death Examiner etimos mariton 200d 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year 4/17/1931 **Funeral** 9. Birthplace (State or Foreign Days 1 X M 2 □ F NEW YORK Director 086-24-6204 72 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or Items 23a or 28e-f show edical Examiner must be notified at Director 1 Yes 2 No BALTIMORE TOWSON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6914 LACHLAN CIRCLE 21239 USA APT. K Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or Itel ury or other traumatic event. It a Medical Evarutes. Black, White, etc. 1 XYes 2 □ No If Yes, Give Year or Dates: KOREAN 1 Never Married 2 X Married 1 ☐ Yes 2 💢 No Specify. Specify: 3 Widowed 4 Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) SUPERVISOR 12TH GRADE DISTILLERY Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CHARLES TEMPLEMAN, SR. CAROLYN FITZGERALD ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6914 LACHLAN CIRCLE APT. K TOWSON, MD 21239 RITA J. TEMPLEMAN WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any injury or ¹ 4 □ Donation /5 □ Other (Specify) 3/17/2004 PARKWOOD CEMETERY BALTIMORE, MD 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signature of Funeral Service Licenses 8521 LOCH RAVEN BLVD. TOWSON, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) gocordia Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death Day Year 5 Other (specify) o 9 Unknown 9 Unknown Division of Vital Records, P. page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | FR/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 ☐ Yes 2 🔀 No the funeral dir this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of After 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 6 Hospital within 24 hours a 16. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the 29b. Signature and title of certifier 0 29c. License number March 14, 30. Name and address of person who completed cause of death (Item 23a) (Type, Pripe Edward Seidel MD 5601 roth 31. Date filed (Month, Day, Year) 32 Registrar's Signature State MAR 1 7 2004 Registrar

				For	State of Mar					Mental Hy	giene ,	2004	. 00501
		- 1		State Registrar AMFND ITFM # 1. Decedent's Name (First, Middle, I	5 PER FH G829 3	3/30/04	<i>Gertifica</i>	te of	Death	2. Date of D	Reg. No.	2004	3. Time of Death
	F	Physici								Month	Day	Year	8:12 A M
		/Medic Examir	J. W. (6)	MILDRED TDA 4a. Facility Name (If not institution, g		_	4b. City	, Town, o	r Location of Dea			ounty of Death	
				Upper Chesapeak				Bel				Harfo	
		Funeral Director	-	213-01-4313	. Sex 7. Age ((In yrs. last bir 80	Yrs. If Under Months		If Under 24 Hrs Hours Min		ay, Year)		place (State or Foreign intry) ryland
		land		Usual Residence of Decedent 10a. State 10b. County	1	I0c. City, Tow	n or Location						10d. Inside City Limits
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		with the Maryland a or 28a-f show be notified at	Director	10e. Street and Number			10f. Zi	p Code			10g. Citize	n of What Cou	intry?
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7	ė,	1 and Healtl am 2		Janet R. Dorer -	Niece	20b. Place of	Disposition (Na	me of	Drive, B	el Alr,		and 2_ tion - City or T	LO15 own, State
0	JOIL	Pages ent of nt: If it		2 Donation 5 Other (Spe			ry, crematory or is of Fa			12/04	Ral+	imore	Maryland
3/10/04	Baltimore, Maryland	permit. Pages 1 and 2 Department of Health a Important: If itam 27 Is any injury or othar tra <u>once</u> .		21. Signature of Funeral Service Lic			22. Name a	nd Addre	ss of Facility Oury Rd.	McComas	Funer	al Home	e, P.A.
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		/Medical Examiner		resulting in death)	Due to (or as a	consequence	of):						
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व	S, P	res that the de signed by the a l be detached f	y Pr	Part II. Other significant conditions	s contributing to death but	not resulting in	the underlying	cause giv	en in Part I.	23e. Did	tobacco use	contribute to (the cause of death?
H	ords	w require been sig should b	ted t							1 🗆	Yes 2□	No 3 ☐ Proi	bably 4 Unknown
Mildred	Division of Vital Record	The lar ate has page 2	Comple							24a. Was auto perf 1 Yes	e an 2 ppsy ormed?	24b. Were auto prior to co death? 1 ☐ Yes	opsy findings available ompletion of cause of とし No
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J.	ō	ding Phys h. After this funeral di	n: To	1 Yes 2 No 27. Manner of Death	Hospital: Inpatient 28a. Date of Injury	28b.		28c. Injur Wor	er: 4 □ Nursing I	dome 5 ☐ Res 28d. Describe			(y)
	ion	Attending Physician: r death. ector: After this certific. by the funeral director,	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigat		rear) i	njury M		K7 Yes 2 □No				
ylor	Divis	i Si te	Certification:	3 Suicide 6 Could not 4 Homicide determine		y - At home, fa (Specify)	rm, street, factor	ry, office			(Street and N wn, State)	lumber or Run	al Route Number,
12	4	To the Hospital or within 24 hours afte To the Funeral Dirt completely filled in I	edicai	29a. Certifier 1 Certifying (Check only one) 1 Medical Ex	Physician: To the best of aminer: On the basis of each manner state	xamination an	e, death occurred d/or investigation	d at the tir n, in my o	ne, date and plac pinion, death occ	e, and due to the urred at the time,	cause(s) an date and pla	d mann <i>e</i> r as s ace, and due t	stated. o the cause(s)
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)		U	David 3	12 m	/		D3	2275		mar	eh 10	2,2004
		10	-15	30. Name and address of person when the state of person when the person when the state of person when the person when	o completed cause of dea	ith (Item 23a) W. M.	(Type, Print))	Be1015	ma			
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		1_ For	State of Maryland	/ Depa	artment of H	lealth and I	Mental Hyg	iene	2001	08582
		Registrar 1. Decedent's Name (First, Middle, Last)		Cei	rtificate of L	Dealli	2. Date of Dea	eg. No.		3. Time of Death
Physic							Month	Day	2004	
/Medi		William H. Utter 4a. Facility Name (If not institution, give si	reet and number)		4b. City. Town, or	Location of Death	March	15 4c. C	ounty of Dear	10:15am
Exami	ner	205 Seagull Drive	, , , , , , , , , , , , , , , , , , , ,			de Grace		На	arford	
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la.	st birthday)	If Under 1 Year	If Under 24 Hrs.			9. Birl	hplace (State or Foreign
Director		227-32-4708 ¹ X	M 2□F 81	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day 07/04/	1922	Ne	w York
ъ,		Usual Residence of Decedent 10a. State 10b. County	10c City	Town or Lo	ocation					10d. Inside City Limits
anyla	5									1)X Yes 2 □ No
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be filed within 72 hours after death with the Maryland hal Hygiene. Id Hygiene. Id other than "natural", or Items 23a or 28a-f ahow event, the Medical Enaminer must be notified at	ā				21078			USA		,
death ms 23	Funeral	205 Seagull Drive	2. Was Decedent Ever in U.S	. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (S	pecify Yes or No-		. Race - Ame	
or Ite	F	1 Never Married 27 Married	Armed Forces? 1▼ Yes 2 □ No If Yes, Give	ĺ	If Yes, specify Cuba 1 □ Yes 2 X No	sn, Mexican, Puert Specify:	o Hican, etc.)		Black, Whit	
Surs and a surs	1 by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates: WW2		TEL TES ZIALNO	зреспу.			Specify: W	hite
72 h 72 h	Completed	15. Decedent's Educ (Specify only highest grade		(Give	dent's Usual Occupa kind of work done of	during most of wor	king	16b. Kind	of Business	Indu <i>s</i> try
Mithin Mithin	d E	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use retired pervisor	1)		Tre	ining	School
filed v Hygie ther i		17. Father's Name (First, Middle, Last)		Su	pervisor	18. Mother's Nan	ne (First, Middle,			JC11001
d be ental	To Be	Clarence Utter				Helen J	ones			
shoul nd Ma	-	19a. Informant's Name/Relationship (Typ	e, Print)	19b. Maili	ng Address (Street a			City or	Town, State, 2	Zip Code)
perillinicie, inter y faith A LACA SOCOOO permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examinat must be notified at once.		Doris M. Utter- W	ife	205	Seagull D	r. Hav	re de Gr	ace,	MD 2	1078
S 1 a of Heigh		20a. Method of Disposition	20b. Pla	ce of Dispo	osition (Name of matory or other place				ation - City or	
Pages tment of tant: If if		1 ☐ Burial 2 💢 Cremation 3 ☐ Re '4 ☐ Donation 5 ☐ Other (Specify)	moval from State	-	rris & Co	1	6/04	West	Chest	ter, PA
Dall. Departin		3. Signature of Funeral Service License		N	Name and Address itchell-Sn	ss of Facility	eral Hom	e. P	. A.	
0 82558	1	ware W	7. Druk	\bigcirc 1	23 S. Was	shington	, Havre	de C	race,	MD 21078
		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the death. e cause on each line.				or respiratory arr	est,		Approximate Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition		-	Sepsi.	5				1 week
/Medical Examiner		resulting in death)	Due to (or as a conseque	ence of):						
Examine	ē	Sequentially list conditions, b	Due to (or as a conseque	ance of):					-	
ted nsit	든	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	0.00 (0. 0.0 0.000)							
be executed ician and burial-transit	Examin	that initiated events resulting in death) Last	Due to (or as a conseque	ence of):						
hat the death certificate be executed of by the attending physician and detached for use as the buriat-transit	cal									
g phy as the	P									
h cent	In/M	23b. was decedent pregnant	3c. If yes, outcome of pregnan		∃Ectopic pregnancy	,		23	d. Date of de	
deatl	sicla	in the past 12 months? 1 🗆 Yes 2 DXNo	4 Pregnant at time of dea		Other (specify)				Month	Day Year
The law requires that the death certificate has been signed by the attending phoage 2 should be detached for use as the	Physiclan/M	9 Unknown								
w requires that the seen signed by the should be detach	þ	Part II. Other significant conditions con	tributing to death but not resul	ting in the u	Inderlying cause give	en in Part I.				the cause of death?
w requires to been significantly be	ted		Alzheen	ierd	Frateria	<u> </u>	1 L Y	es 2 🗆		obably 4 Dunknown
law has b	Completed		Hypert	ense	or		24a. Was a autops	sy	prior to	topsy findings available completion of cause of
	S		Parken	sons	Dise.	US.	perfor	2 No	death?	2 🗆 No
OI VILGI DEC Physicien: The lav rhis certificate has	Be	25. Was case referred to medical examiner?	ospital:		- Othe		ath (Check only or			
Phys this	5	1 Yes 2 No	1 Inpatient 2 E	R/Outpatie 28b. Time o		er: 4 ☐ Nursing H	lome 5 Peside 28d. Describe he			cify)
ding Th. After	ţ	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	Worl	k? Yes 2 □ No				
VISION Attending or death. rector: After by the fune	flca	3 Suicide 6 Could not be	28e. Place of Injury - At hon		reet, factory, office				Number or Ri	ural Route Number,
affer or din the	Certification:	4 Homicide	building, etc. (Specify)				City or Town	n, State)		
pspite hours unera	al	29a. Certifier 1 ← Certifying Phys (Check only 2 ← Medical Exemin	ician: To the best of my know	ledge, deat	h occurred at the tim	ne, date and place	, and due to the c	ause(s) a	nd manner as	stated.
To the Hospital or Attanding within 24 hours after death. To the Funeral Director: After completely filled in by the funer	ledical	one)	er: On the basis of examination and manner stated.	and/or in						
To t To t	Σ	29b. Signature and title of certifier	1RZA A-B.	A16,	41) 29c. License			7	signed (Mont	
		15229	,		10	43 115		3	-16-	14
10+1		30. Name and address of person who co	mpleted cause of death (Item:	23a) (Type,	Print)	Bne	ce . 11	7)	210	78
		31. Date filed (Mortal 24), Year) 7 7	NA 32/Herbistrar's Signatu		and a	0,.50	-) /*!	ンラ		- 0
Si Regis	tate		A 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	17						

			1 - For State Registrar	State of Ma		epartment of F			giene 200 L	08583
	Physic		1. Decedent's Name (First, Middle, L	ast)				2. Date of Dea Month	th Day Year	3. Time of Death
9	/Medi Exami		4a. Facility Name (If not institution, g	ive street and number)			Location of Deat		4c. County of Deer	th
	<u> </u>		5. Social Security Number 6.	Hospice Sex 7. Age	(In yrs. last birth		If Under 24 Hrs	8. Date of Birth	BALTIN	thplace (State or Foreign
z i	Funeral Director			1 M 2 F	-	Months Days	Hours Min		Year) Co	ountry) M.
	and *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
	Maryla	tor		Timore	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	£55 ex				1 Yes 2 No
	ith the or 28a	Funeral Director	10e. Street and Number			10f. Zip Code		1	Og. Citizen of What Co	
•	s 23a	eral [LEAS RUN	RD.		1221	Construction or No-	14. Race - Ame	
p.d	after de	Fune	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 Tes 2 Tes		13. Was Decedent of H If Yes, specify Cuba		to Rican, etc.)	Black, Whit	e, etc.
	of filed within 72 hours after death with the Maryland of Hogene. Other than "natural", or flems 23a or 28a-1 show ent, the Modical Expendient and De notified at	d by	3 Widowed 4 □ Divorced	Year or Dates:		1 Yes 22 No			Specify: W	hite
4:23	in 72 t	Completed	15. Decedent's (Specify only highest g	rade completed)		Decedent's Usual Occup Give kind of work done (life. DO NOT use retired	durina most of wo	rking	16b. Kind of Business/	Industry
21.0	d with giene.	Com	Elementary/Secondary (0-12)	College (1-4or 5-	+)	Medical	cleak		Hospita	i L
1, 2004 Maryland	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other then any injury or other treumatic event, the MODE.	Be	17. Father's Name (First, Middle, Las					me (First, Middle, i	Maiden Sumame) Fogharī	
20 1	should be fand Mental Pand Men	2	19a. Informant's Name/Relationship		19b. I	Mailing Address (Street				
11,	and 2 seatth ar n 27 ls		EARL . J. Whit	e, JR	13	2127 BOTT	on wood L			
q	ges 1 stoff He if item or oth		20a. Method of Disposition Burial 2 Cremation 3	Removal from State		Disposition (Name of crematory or other place	(8)		20c. Location - City or	
March	iit. Pa intmen intant: injury		4 □ Donation 5 □ Other (Spec 21. Signature of Funeral Service Lic	cify)	Meado	22 Name and Addre	ss of Facility	6104	ELKRIDGE.	, 140.
מ מ	Depa Impo Impo		Yaul M.	Stilla		HARTLEY M	WER-ST	Balto	CAI Home C NO 2123	34
	By Arrange Company		23a. Parti. Enter the disease, or co	nplications that caused y one cause on each lin	the death. Do no					Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	и	atic Cand		. .			
	Examiner		Sequentially list conditions	b						
	be is	liner	Sequentially list conditions, if any, leading to immediate cause. Erner underlying Cause (Disease or injury		consequence of):				
	be executed sicien and burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a	a consequence of):				
Mite Roy 68760	eath certificate be exattending physicien for use as the burra	cail		L d.						
te	ertifica ding pt	Med	IF FEMALE:	23c. If yes, outcome of	of organizati					
White	leath c attend	Physician/Med	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at t	2 Fetal death	3 Ectopic pregnancy 5 Other (specify)			23d. Date of del Month	ivery Day Year
Rita	at the c by the	hysi	9 Unknown	9□ Unknown						
Ri Division of Vital Records		by	Part II. Other significant conditions	contributing to death bu	ut not resulting in t	he underlying cause giv	en in Part I.		bacco use contribute to es 2□No 3□Pr	the cause of death? obably 4XIUnknown
Ç	law requir as been si 2 should l	Completed						24a. Was a	n 24b. Were au	itopsy findings available
ă	The ate h	Com						perform	med? death? 2 X No 1 ☐ Yes	2 No
Vita	or Attending Physician: Thirdier death. Director: After this certificate in by the funeral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		oth Oth		ath (Check only on		
Č	g Physe er this	n: To	1 ☐ Yes 2 X No 27. Manner of Death	1 ☐ Inpatier 28a. Date of Injun (Month, Day		ne of 28c. Injur	4 🗆 Nursing i		ence 6 Other (Specow injury occurred	cify) Hospice
	endin eath. or: Aft	atio	1 XNatural 5 Pending 2 Accident investigati	on	1921)		Yes 2□No			
şiyiç	or Att after de Direct in by t	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		iry - At home, farr :. (Specify)	n, street, factory, office		28f. Location (St City or Town	treet and Number or Ru n, State)	ural Route Number,
1-/	To the Hospitel or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	al Ce	29a. Certifier 1X Certifying I	Physician: To the best o	of my knowledge,	death occurred at the tin	ne, date and place	e, and due to the ca	ause(s) and manner as	stated.
	To the Ho within 24 I To the Fu completel	ledical	one)	ammer: On the basis of and manner stat	examination and/ ted.					
	To Toon	Σ	29b. Signature and title of certified	- /~		29c. Licens	e number 1 7 7 2 5		9d. Date signed (Monti	
	10		30. Name and address of person wh	o completed cause of de	eath (Item 23a) (T		1 1 2 3		March 11,	2004
	10		Dr. Tariq Ma			Valley Ro	ad, Timo	nium, MD	21093	
	St Regist	ate rar	31 Date filed (Month Ta, Drear)	2004 32. Receive	iye Signature	7				

Rita White

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month Year Physician 2:56pm 15 2004 Young W. Orly 4b. City, Town, or Location of Death Mour Clara Virginia /Medical 4e Fecility Neme (If not institution, give street end number) 4c. County of Deeth Examiner Baltimore Mercy Hospital If Under 1 Year 7. Age (In yrs. lest birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Months Deys 1□ M 2♥ F Yrs 86 Director DE 220-12-9647 Usuel Residence of Deced permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Haalth and Mental hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 ehror any injury or other treumsite aven. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits XX es 2 □ No Funeral Directo MDNA Baltimore 10g. Citizen of Whet Country? 10f. Zip Code 10e Street and Number 21201 833 West Pratt Street U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Raca - American Indian, Black, White, etc. 11. Maritel Status Yes, Give XX 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Specify: Be Completed by 3√ Widowed 4 Divorced Black 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decadent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12th grade Home Maker Own Home na 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) <u>Anna Fulman</u> John Polk 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. tnformant's Name/Relationship (Type, Print) Bridget D. Young 16705 Governor Bridge Rd #108, Bowie Md 20716 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, State King Memorial Park 3/20/04 Randallstown, Md 21. Signature of Funeral Service Licansee March F/H West 4300 Wabash Ave, Baltimore Md 21215 art1. Her the diseese, or complishock, or heart failure. List onty or tions lief caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest Approximate Interval Between Onset and Death Physician Immediate Ceuse (Final disease or condition resulting in death) /Medical Cancer Examiner Due to (or as a consequence ot): Physician/Medicai Examiner nding physician and use as the bunal-transit or Attending Physicien: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Due to (or as a consequence of) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? 1 Yes 22 No 3 Probably 4 Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of deeth? Aftar this certificata has been signaral director, paga 2 should b 24a. Was en eutopsy performed? 1□ Yes 2☑No 1 Yes 2 No 25. Was case referred to medical 26. Plece of Death (Check only one) Hospitel: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) NOSpice 1 Yes 2 No Certification: To 2 ☐ ER/Outpatient 3□ DOA 28e. Dete of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Injury 1 Naturel nours aftar death.

nerel Director: Aft
filled in by the fur 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital of within 24 hours at To the Funerel D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the bests of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) Medical (Check only one) completely and menner stated 29c. License number 29b. Signature and title of certified 29d. Date signed (Month, Day, Yeer) 30. Name end eddress of person who completed cause of deeth (Item 23e) (Type, Print) Baltimore Risebur 301 Livia 31. Date filed (Month, Day, Year) 32 Registrar's Signeture State Registrar

			For	State of M	laryland / De			-		gible.	
			= State Registrar		C	ertificate of	Death		Reg. No. 2	004	08585
	Physici	an	1. Decedent's Name (First, Middle,	Last)				2. Date of De Month	eath Day	Year	3. Time of Death
	/Medic		Victor Lee			11. C't. T		March_			5:30 A M
	Examin	er	4a. Facility Name (If not institution, 1205 Hanson Ro		/	Edgewo	or Location of Death			ity of Death Jarford	7
	Funeral			5. Sex 7. A	ge (In yrs. last birthda		If Under 24 Hrs.	8. Date of Bi (Month, D			lace (State or Foreign stry)
	Director		228-16-2593	1 ∑ M 2□F	91 Yrs.	Mortins Days	Hours Mill.	June 1		Vir	jinia
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location				1	0d. Inside City Limits
	Maryl -f sho	ţō	Maryland Harfo	ord	Churchy	ville					1 ☐ Yes ŽŽNo
	n the or 28a e notil	Director	10e. Street and Number			10f. Zip Code			10g. Citizen o	f What Cour	itry?
	death with the Maryland ms 23a or 28a-f show	rai	304 Priestfo				1028		US.		
	ter de Itams Lerri	Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie	12. Was Decedent	t Ever in U.S. 13	I. Was Decedent of H If Yes, specify Cub	dispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)	0- 14. R	ace - Americ lack, White,	
980	72 hours after natural', or Its olcel Exemine	þ	3 ☑ Widowed 4 ☐ Divorced	d 1 □Yes 2 🔀 If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ No	Specify:		Spec	ity: Wh	ite
21215-0036	72 ho	Completed	15. Decedent's (Specify only highest	Education grade completed)	16a. Dec (Gi	edent's Usual Occup re kind of work done DO NOT use retire	oation during most of work	king	16b. Kind of	Business/Inc	dustry
121	within ene. than "	idmo	Elementary/Secondary (0-12)	College (1-4or	5+)		d)		Dode	. Полен	
	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Mental	Be Co	17. Father's Name (First, Middle, La	ast)		armer	18. Mother's Nam	e (First, Middle		y Farm _{ame)}	L
/lan	should be nd Mental marked o	To B	Stephen Thoma	as Yonce			Lura		okaste:		
Maryland	2 sho and Is ma		19a. Informant's Name/Relationshi			iling Address (Street				n, State, Zip	Code)
	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If item 271s marked other than "natural", or Itams 23a or 28a-f show or other traumatic event, the Modical Examiner must be notified at		Lana C. Thomas	s / Daugnte		Marble Ar position (Name of ematory or other place		Date	2191 / 20c. Location	n - City or To	wn. State
Ď	Pages nent of int: If it		1 Burial 2 Cremation 3		9			16-04	Bel Ai:		
Baltimore,	permit. Page Department o Important: If any injury or once.		21. Signature of Funeral Service Li			McConsor F				L, PMI	ylana
ä	Depariming of the policy of th		Stylly as	Kulfy		1317 Coke	sbury Roa	d, Abir	ngdon, l	MD 210	09
			23a. Part 1. Enter the disease, or c shock, or heart failure. List o	omplications that cause nly one cause on each	line.				0		Approximate Interval Between Onset and Death
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	and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (oral	Zueun Sa consequence of):	ner's 1.	Jemen	itia			- years
760,	icate be executed physician and s the burial-transit	ai E		1	arkins	on!	Dixie	-0			7 2 years 72 years 72 years
89	that the death certificate ed by the attending phys detached for use as the	ledic	T arrain Rowalism	0.		PERMANDE DE LA COMPONIO	CD-UK				
Вох		Physician/Med!	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		2 Fetal death	□Ectopic pregnanc	у			ate of delive	ry Day Year
	he dea the al	ysici	1 Yes 2 No	4□Pregnant a 9□Unknown	at time of death	☐ Other (specify) _				NOTE:	Day 10a
P.0	requires that the death een signed by the atter hould be detached for u		Part II. Other significant condition	s contributing to death	but not resulting in the	underlying cause giv	ven in Part I.	23e. Did	tobacco use co	ntribute to th	e cause of death?
rds	w requires that been signed be should be deta	ed by	Ineum	ina,	termi	al Er	rent	10	Yes 2 □ No	3 Prob	ably 4 Unknown
Vital Records,	aw 1s b	Completed	Chronic	Chalin	time 1	mase	Lecas	24a. Was	psy	prior to cor	psy findings available inpletion of cause of
<u>~</u>	That are page	Con						perfe 1 Yes	ormed? 2 1 No	death?	2 No
<u> </u>	Physician: The this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	ient 2 ☐ ER/Outpat	ott	26. Place of Dear			(2)	Bookding
6.0	sing Phys I. After this funeral di	 	27. Manner of Death	28a. Date of Inj	ury 28b. Time	of 28c. Injur	4 Nursing Ho		how injury occ		1 Hone
sior	Attending ir death. ector: After by the fune	catio	1 Natural 5 Pending 2 Accident investigs 3 Suicide 6 Could no	ation		M 1 🗆	Yes 2 □ No				
Division	or Att	Certification;	3 Suicide 6 Could no 4 Homicide determin	286. Place of ir	njury - At home, farm, etc. <i>(Specify)</i>	street, factory, office		28f. Location (City or To	(Street and Nun wn, State)	nber or Rura	l Route Number,
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	ai Ce	29a. Certifier 1 Certifying	Physician: To the bes	t of my knowledge, de	ath occurred at the ti	me, date and place,	and due to the	cause(s) and	manner as st	ated.
	he Ho in 24 t he Fu pletely	edicai	(Check only 2 Medical E	xaminer: On the basis and manner s	of examination and/or	investigation, in my o	opinion, death occur	red at the time,	date and place	e, and due to	the cause(s)
	To t To t	Σ	29b. Signature and title-of certifier	- Days	2 52	29c. Licens		9	29d. Date sign	ned (Month,	Day, Year)
	10		France	the complete	doub (lease on a) T		\$1638	<i>'</i>	1.81	m/	1, 2004
	¥	No. of Concession, Name of Street, or other party of the Concession, Name of Street, or other party of the Concession, Name of	PER FECTO C.	VALAR AS	death (Item 23a) (Type HD, 171		RP RD	FALLS	TON L	102	1047
		ate	31. Date filed (Month, Day, Year)	P	1 O' 4	Sparks					
	Regist	rar	MAR 1 7 200	Allen	for 1	age very					

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death MARCH 13, Day 2004 **Physician** JAE AK YANG 8:35 P M /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MARINER HEALTH AT NORTH ARUNDEL GLEN BURNIE ANNE ARUNDEL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year FEB. 15, 1 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign 6 Sex **Funeral** 1 M 2 F Months 219-27-3537 74 1930 SOŬTH″KOREA Director Usual Residence of Decedent with the Maryland 10d Inside City Limits 10c. City. Town or Location 10a. State 10b. County r than "natural", or items 23a or 28e-f show the Medical Examinar must be notified at 1 ☐ Yes 2 No HOWARD COLUMBIA MARYLAND Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8421 GLAD RIVERS ROW 21075 UNITED STATES death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married or ! Baltimore, Maryland 21215-0036 1 □ Yes 2 No Specify: Specify: þ ASIAN 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Peges 1 and 2 should be filed within 72. Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "na any injury or other traumatic event, Ita Media once. Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be CHANG H. YANG HEE B. BAE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8421 GLAD RIVERS ROW, COLUMBIA, MARYLAND 21075 KANG HEE LEE / SON MARCH 16, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State * 4 □ Donation 5 □ Other (Specify) GLEN HAVEN MEM. PK. GLEN BURNIE, MARYLAND 21. Signature of Fureral Service License FUNERAL HOME, P.A. S.E., GLEN BURNIE, MD 21061 0 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** metretic CONC MOMA year disease or condition resulting in death) /Medical Due to (or as a consequenca of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetel death 3 Ectopic pregnancy Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 4 Pregnant at time of death 5 Other (specify) P.0. the detached 9 Unknown 9 Unknown signed by Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. by 3 ☐ Probably 4 ☐ Unknown 1 Yes 200 No Completed been (24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 3 DOA 2 2 ER/Outpatient this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Hospitel or Attending 1 X Natural Injury 5 Pending within 24 hours after death. To the Funerel Director: A 1 Tyes 2 🗌 No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) the 29b. Signature and title of centiler 29c. License number 29d. Date signed (Month, Day, Year) D19512 MARCH 15, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1600 CRAIN HWY., S.W., SUITE 206, GLEN BURNIE, MD 21061 SANG CHEOL DOH, M.D., 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar MAR 1 7 2004

973			1 - State Registrar	State of Maryland / D		ent of H ate of L			R	eg. No.	2004	085	58 7
	Physici /Medio			epp	45.6	. T.		1	2. Date of Deat Month March 1.	2, Day 20		3. Time of E	Death P ^M
	Examir Funeral	ner	4a. Facility Name (If not institution, give stre 318 S. Taylor Avenue 5. Social Security Number 6. Sex	7. Age (In yrs. last birth	E	City, Town, or SSEX Inder 1 Year ths Days	If Under 2		8. Date of Birth (Month, Day, Dec. 8, 1)	Ba	9. Birthpl Maryl	ace (State or	Foreign
	Director works 1 show	tor	214-16-8268 Usual Residence of Decedent 10a. State 10b. County Maryland Baltimore	10c. City, Town Essex	or Location				Jec.8, I	920		od. Inside City	
	h with the 23a or 28a 14 be noti	Funeral Directo	10e. Street and Number 318 S. Taylor Avenue	2	1	Zip Code 1221			1	-	n of What Coun	try?	*
020	s 1 and 2 should be filed within 72 hours after death with the Maryland f Healith and Mealier Hygiene f Healith and Mealier Hygiene other treumatic event, the Medical Example must be notified at	by	11. Marital Status 12. 1 Never Married 2 Married 3 Widowed 4 Divorced	Was Decedent Ever in U.S. Armed Forces? 1202Yes 2 □ No 1942- If Yes, Give Year or Dates: 1945		specify Cuba	spanic Orig n, Mexican, Specify:	in? (Spec Puerto P	cify Yes or No- lican, etc.)		Race - America Black, White, e pecify: Whi	etc.	
7-61717	ad within 72 h rgiene. ar than "natu t, the Medical	Completed	15. Decedent's Educati (Specify only highest grade co Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind o	Jsual Occupa work done d Tuse retired	lurina most	of workin	g		of Business/Ind L Mill	ustry	
yland	ould be file Mental Hy narked oth	To Be	17. Father's Name (First, Middle, Last) Hershall Zepp				Fann	ie G	(First, Middle, M rimes				
Ĕ	d tre		19a. Informant's Name/Relationship (Type, Doris Zepp (Wife)	· ·	18 S.	Taylor		ue, 1	Essex, 1	Mary]	own, State, Zip Land 212	221	
Daillinor	permit. Peges 1 an Department of Heali Important: If Item 2 any injury or other once.		20a. Method of Disposition 1	cometan	oly Re	or other place deemer	M	arch			tion - City or Tov		and
ę.	Physician /Medical Examiner		23a. Part1. Ent. the durse, or complicat shock, mean failure. List only one of Immediate ause (Final disease or condition resulting in death)	ions that caused the death. Do no ause on each line. Due to (or as a consequence or	14	07 Old	uzdzi Fast g, such as c	nski ern ardiac or	Avenue,	Esse		Approximate Interval Betwee Onset and De	een
	The law requires that the death certificate be executed at the bas been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of									
O. DOX O	the death certifi y the attending ched for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	If yes, outcome of pregnancy 1 Live birth 2 Fetel death 4 Pregnant at time of death 9 Unknown	3 □Ectopi 5 □ Other	c pregnancy (specify)				23d	I. Date of deliver Month i	y Day Ye	ar
r (spins)	quires that an signed b uld be deta	by	Part II. Other significant conditions contrib	outing to death but not resulting in	the underlyin	ng cause give	n in Part I.			acco use	contribute to the	cause of dea	
מו שבנים	i: The law re icate has bee r. page 2 sho	Completed							24a. Was an autopsy perform	/	death?	sy findings av pletion of cau	
01 VII.	Physician: rthis certifica ral director, p	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	oital: 1 ☐ Inpatient 2 ☐ ER/Outp	patient 3	DOA Othe			(Check only one e 5-⊋Resider		Other (Specify)		
	ending Peath. or: After the funera	Certification:	1 Accident 5 Pending investigation	28a. Date of Injury 28b. Ti (Month, Day Year) Inj	me of jury M	28c. Injury Work	at ? ∕es 2 □ N		3d. Deścribe ho	w injury o	ccurred		
	To the Hospitel or Attending Physician: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2.		4 Homicide determined	28e. Place of Injury - At home, farr building, etc. (Specify)					City or Town,	State)	lumber or Rural		ir,
	he Hosp in 24 hou he Fune pletely fi	edicai	29a. Certifier 1 Certifying Physici (Check only one) 2 Medical Examiner:	an: To the best of my knowledge, On the basis of examination and and manner stated.	death occur /or investiga	red at the tim tion, in my op	e, date and inion, death	place, an	nd due to the ca	use(s) and te and pla	d manner as sta ace, and due to t	ted. he cause(s)	
}	or take to	Σ	29b. Signature and title of certifier	ilam M.D		29c. License		`			igned (Month, D		1.4
	6		30. Name and address of person who comp	leted cause ol death (Item 23a) (T	ype, Print)				A 1 D		21236	,	7
	Sta Registr		31. Date filed (Month, Day, Year) MAR 1 7 2004	32. Registrar's Signature	CORC	200 400	7		, 100		-123		

State of Maryland / Department of Health and Mental Hygieney 08588 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** MARCH 2004 23:30 GENEVIEVE ARCZYNSKI /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner GENERAL HOSPITAL CARROLL WESTMINISTER CARROLL CO. If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplece (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number Days Hours Funeral 1 □ M 2 🗷 F Director 83 12/31/20 MARYLAND 218-01-1031 Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a, State 10b. County id Menial Hygiene. marked other than "natural", or Itams 23a or 28a-1 show matic event, the Medical Examinar must be nutified at 1 ☐ Yes 2 No Director ROSEDALE BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21237 7914 35th STREET USA Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Affined Porces? 1 ☐ Yes 2 🔁 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No 21215-0036 Specify 3 X Widowed 4 ☐ Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 8 Ò ASSEMBLY PERSON BENDIX RADIO 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) Be 1 and 2 should be f Health and Mental P VERONICA RATAJCZAK ဂ္ STANISLAUS TRCZINSKI 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21237 7914 35th ST. BALTIMORE, MD. RICHARD ARCZYNSKI Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Importent: If ite any injury or ot once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State GARDENS OF FAITH 3/18/04 ROSSVILLE, MD. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service KACZOROWSKICHTUNERAL HOME P.A. 1201 DUNDALK AVE. BALTIMORE, MD. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition **Physician** Acute Museervale resulting in death) /Medical Due to (or as a consequence of) Examiner TO (OF AS A CONSEQUENCE OF). Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed OPP-EM Due to (or as a consequence of): attending physician a for use as the burial-Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐ Yes 2 No o 9 Unknown 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, Completed by 1 Yes 2 □ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? Yes 2 No certificate 1 Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 1 Yes 2 No 3□ DOA Certification; To 2 ☐ ER/Outpatient this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No s after death. investigation the t 6 Could not be determined 3 🗋 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide within 24 hours a To the Funeral C Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medicai (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated. in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) March 15th 1)37940 30. Name and address of person who completed cause of death (Item 23a) 95 Seiner Aue Westminister MU, 21157 Alexander Bo 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 1 8 2004 Registrar

			1 - For State Registrar	State of	Marylan	nd / Depa <i>Cer</i>	artment of F tificate of	Health and I Death	Mental Hy	giene () () ل	08589
	Physic		Decedent's Name (First, Middle, L ANGELA	ast)		ARI	MSTRONG		2. Date of De Month		Year 1	3. Time of Death 12:38p M
	/Medi Examir		4a. Fecility Name (If not institution, gr	ve street and numb	per)	AIV		or Location of Death		4c. County of		12.500
	-Admi		Joseph Ritchie	Hospice				timore		N/		
	Funeral Director			Sex 7. 1 □ M 2 ☑ F	. Age (<i>In yr</i> s. 44	last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Bid (Month, Date of Bid)		9. Birthple Country	ice (State or Foreign y)
	D		Usual Residence of Decedent						J-20			d tasida Chatiania
	arylar show	_	10a. State 10b. County		10c. Ci	ty, Town or Lo					100	d. Inside City Limits 1 ☑ Yes 2 ☐ No
	he M.	ecto	Md. NA			Baltin	nore			10g. Citizen of W	hat Countr	
	with with the party	급	2745 Baker Stre	a t				1216		USA		,
	death with the Maryland ms 23e or 28e-1 show rrust be nutilised at	Funeral Director	11. Marital Status	12. Was Deced Armed Ford	ent Ever in U	I.S. 13.		Hispanic Origin? (S ean, Mexican, Puert	pecify Yes or No		- Americar	n Indian,
	after or Ite		1 ☐ Never Married 2 ☐ Married	1 Tes 2	No No	1	r Yes, specify Cub I∐ Yes 2√∏ No		o ricen, etc.)	Specify:		
	DOO3	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dat	es:					16b. Kind of Bus		ack
	21215-0036 ad within 72 hours aft giene. or than "natural; or the Madical Event	Completed	15. Decedent's I (Specify only highest g	rade completed)		(Give	kind of work done OO NOT use retire	pation during most of wor id)	rking	166. Kind of Bus	sinessindu	Stry
	212 I with	mo	Elementary/Secondary (0-12) 10th grade	College (1-4	tor 5+)		esser			Rainbov	v Clea	aners
	al Hyg	BeC	17. Father's Name (First, Middle, Las	t)				18. Mother's Nan	ne (First, Middle	, Maiden Sumame	9)	
	Maryland od 2 should be file lith and Mental Hy 27 1s marked other traumatic event.	70	George	К.	Armst			Will			ewart	
	Mar 12 sh and 18 m		19a. Informant's Name/Relationship					and Number or Au				
als	t and thealth		Willa Mae Stewal 20a. Method of Disposition	rt M	other 20b. F	Place of Dispo	sition (Name of	m Ave., B	altimore Date	e, Ma. 20c. Location - 0	21213 City or Tow	
2/2	ages ant of ht: If It		1 Surial 2 Cremation 3		iate	cemetery, crer Ling Mei	natory or other pla m Pk	1	9-04	Randal]	Istow	n, Md.
12	Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturat; or Items 23e or 28e-1 show amy injury or other traumatic event, Ite Madical Examinat must be nutilised at once.		21. Signature of Funeral Service Lice		1,		. Name and Addre					202
	Bal permi Depar Impor		I free Co	Ray			Marcn F.	H. East		more, Md. . North A		202
			23a. Part1. Enter the disease, or co- shock, or heart failure. List on	mplic tions that car y one cause on ea	used the deat ch line.	th. Do not ent	er the mode of dy	ng, such as cardiac	or respiratory a	rrest,	, , 1	Approximate Interval Between Onset and Death
50	Physician		Immediate Cause (Final disease or condition resulting in death)	_a	dro	Inon	TO OF	12501	harv	MX WI	th	3Vrs
200	/Medical Examiner		resulting in death)	Due to (o	r as a consec	quence of):			m	1/2		1
3		-er	Sequentially list conditions, if any, leading to immediate	b. — Due to (o	r as a consec	quence of):			///			
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RCL	50, e exe sian ar urial-t	Ex	resulting in death) Last	Due to (o	ras a consec	quence of):						
A	68760, ficate be executed physician and is the burial-transit	dlcai	•	d								
3			IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco						23d. Date	of delivery	/
	. Box (death certified e attending d for use a	Physiclan/M	in the past 12 months?	4 ☐ Pregna	th 2 ☐ Feta nt at time of o		Ectopic pregnanc Other (specify) _	y .		Mon	th D	Day Year
3	P.O.	hys	9 🗆 Unknown	9□ Unknov	vn				71			
ARMST RONG	ds, F	by	Part II. Other significant conditions	contributing to dea	ath but not res	sulting in the u	nderlying cause gr	ven in Part I.		tobacco use contri Yes 2 □ No		
9	Or requ	Completed							-			
25	Aec ne law has b	I de							24a. Was auto perfe	psy pr	rior to comp eath?	sy findings available pletion of cause of
d)	in: Th	e Co	25. Was case referred to medical					26. Place of Dea			□ Yes 2	□ No
*	ysicia ysicia is cert direct	To B	examiner? 1 \(\sum \text{ Yes} \) 2 \(\sum \text{ No} \)	Hospital:	patient 2] ER/Outpatier	it 3 DOA Ot		lome 5 ☐ Res		r (Specify),	HDADICO
4	n of ng Phys ter this neral di		27. Mann of Death 1 Natural 5 □ Pending	28a. Date of (Month	Injury , Day Year)	28b. Time of Injury	28c. Inju Wo			how injury occurre	ed /	10/100
N/	SiOI tendir eath. or: A	catle	2 Accident investigat	fin -				Yes 2□No				· .
ANCELA	Division or Attending after death. Director: After	Certification;	4 Homicide determine	208. Flaue	of Injury - At h g, etc. <i>(Speci</i>	iome, farm, str <i>fy)</i>	eet, factory, office			(Street and Numbe wn, State)	r or Hural I	Houte Number,
4	Division of Vital Re within 24 hours after death. To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page							ime, date and place				
	ne Hoor 24 h	Medical	(Check only 2 Medical Ex	aminer: On the bas and manne	sis of examina or stated.	ation and/or in	vestigation, in my	opinion, death occu	rred at the time,	date and place, a	nd due to ti	ne cause(s)
	To th withir To th	Me	29b. Signature and title of certifier	1. 1.	0		29c. Licen	se number		29d. Date signed	(Month, Da	ay, Year)
	•		1 June 10	1/am	all		1/1	30/2		3/14	104	2
	1		30. Name and address of person wh	o completed sause	of death (Ite	m 23a) (Type,	Print)	2/ B.	Himo.	on Mil	210	10
		ata	31. Date filed Man 1/1 Dy. 1940	000 320 Re	gistrar's Sign	atyre	11/1/1/1/	40,	1 111101	C) 11/11 -	4/	0
	Regist	ate trar	MARK, T. O. S.	.004	Termo ,	OF A	4421					

RKD State of Maryland / Department of Health and Mental Hygiene200 , 08590 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 12, 2004 MARCH 1:45P. /Medical 4a. Fecility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Deeth 2015 E.LAFAYETTE AVE BAITIMORE CITY
If Under 1 Year | If Under 24 Hrs. NIA 7. Age (In yrs. last birthday) Social Security Number 8. Date of Birth (Month, Day, Birthplece (State or Foreign Country) **Funeral** 213-84-5908 Days Year) 1 X M 2 □ F Director AUG-21,1965 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location or 28a-f show 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylai ment of Health and Mental Hygiene.
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1 ☑Xes 2 □ No 24a. Was an autopsy performed? 1 Yes 2 □ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specific CENE) 1 XYes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA ie Hospital or ».. in 24 hours after death. in 24 hours after death. in all Director: After th' 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 🗌 Yes 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours at To the Funeral D 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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State Registrar

31. Date filed (Months Pay,

32. Registrar's Signature

MO

111 Penn Street, Baltimore, Maryland 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 08591 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** BRUCE ECKLES BELIN March 14, 2004 3: 16 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Greater Baltimore Medical Center Towson Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. AUG 1. Pay. 1996 0 5. Social Security Number 6. Sex 1 ★M 2 ☐ F 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Months 43 MARYLAND 215 76 4060 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits of Health and Mental Hygiene.
If item 27 is marked other than "natural", or Itams 23a or 28a-1 shov or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No N/A BALTIMORE Directo MD. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3813 BOWERS AVENUE 21207 U.S. OF Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 □ Yes 2 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: þ Specify: 3 Widowed 4 Divorced BLACK Year or Dates: Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12TH PROPERTY MANAGER YEARS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ROY L. BELIN LULA MAE FISHER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROY L. BELIN (FATHER) 3813 BOWERS AVENUE BALTIMORE, MD. 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ■Burial 2 □ Cremation 3 □ Removal from State permit. Page Department o Important: If eny injury or once. KING MEMORIAL PARK 3/19/04 BALTIMORE, MARYLAND ` 4 Donation 5_Other (Specify) upmal Service Liger LEWIS T. GWYNN FUNERAL HOME BALTIMORE, MI 21. Signature of **GWYNN** 4517 PARK HEIGHTS AVENUE BALTO., MD. 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS-SEVERE **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Que to for as a consequence of To the Hospitel or Attending Physicien: The law requires that the death certificate be executed physician a s the burial-t Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown ditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 1 Yes 2 No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 npatient 2 ER/Outpatient 3 DOA P : After the 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Matural 5 Pending investigation death. I Director: A 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funerel Dire 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medicai 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

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32 Tegistrar's Signatur

			1 - For State Registrar	State of Maryland		artment of I rtificate of		nd Menta	l Hygiene	ZHHA	08592
	Physici /Medic		1. Decedent's Name (First, Middle, Last) H9RRiette	Banks			<u>.</u>	Mar	4 16	2004	3. Time of Death
	Examin	er	4a. Fecility Name (If not institution, give: BCYSECAND NO. 5. Social Security Number 6. Sex	Spital	st birthday)	4b. City, Town, of Bally Mul	If Under 2	M PAN 4 Hrs. 8. Date	y/aud	County of Deeth	place (State or Foreign
Ç,	Funeral Director		215-22-637Z 1D	IM 256 F 8/	Yrs.	Months Days	Hours		nth, Day, Year)	2 1	Mary land
	ne Marylar 8a-f show oillied at	ector	10a. State 10b. County		A LTO						10d. Inside City Limits 1 A Yes 2 No
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980	ours after d	þ	11. Marital Status 1 Never Married 2 Married 3 Nowled 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of Information of Yes, specify Cub		Puerto Rican, e	itc.)	Black, White,	etc.
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "netural; or items 23e or 28e-f show simportant: If item 27 is marked other then "netural; or items 23e or 28e-f show shy injury or other traumatic event. The Mcdical Examiner rusal be multified at ance.	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		(Give life.	dent's Usual Occup kind of work done DO NOT use retire	during most o	of working	11	and of Business/Ir	ndustry
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Baltimore,	permit. Pages Department of I Important: If it any injury or o		1 Surial 2 □ Cremation 3 □ R '4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License	emoval from State	bytus	Memory Name and Address	al Com.	3-73-0		, 5048	4d
8	permi Depa impo any ir	//. I	23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the death.	Do not ent	er the mode of dyin	Down of	S Funera	atory arrest,	c. P.A Bo	Approximate Interval Between
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a conseque	ion	YDpa					Onset and Death
	outed id	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conseque	ense of):						
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P.O. Box 68760	e death certific the attending pade for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregnan 1 □ Live birth 2 □ Fetal c 4 □ Pregnant at time of dea 9 □ Unknown	death 3□	Ectopic pregnanc	y			23d. Date of deliv Month	ery Day Year
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of Vital	Physician: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 \(\text{Yes} \) 2 \(\text{No} \) No	ospital: 1 🗆 Inpatient 2 🍑	F/Outpatien	t 3□ DOA Oth	or:	of Death (Check	12 CA 1 C C C C C	6 □Other (Specia	(y)
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Divi	Hospital or Attending 24 hours after death. Funsral Director: Attentely filled in by the fune	Certifi	4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)				City	or Town, State		
	To the Hospital or Attent within 24 hours after death To the Funsral Director: completely filled in by the	ledical	one) 2 Medicai Exami	sician: To the best of my know ner: On the basis of examination and manner stated.	ledge, death on and/or inv	estigation, in my o	opinion, death	place, and due occurred at the	time, date and	d place, and due to	o the cause(s)
	To T	M	29b. Signature and title of certifier		20-1-7	Be 7		33		te signed (Month,	
	4		30 Name and address of person who co	mpleted cause of death (Item 2		Print)					
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	Physicia /Medic		John Bolyard, II					March	12, 200	4	1045 P ^M	
2	Examin	er	4e. Facility Name (If not institution, give street and Bon Secours Hospital	d number)		4b. City, Town, or Baltimor		ith	4c. County	y of Deeth		
	Firmural		5. Social Security Number 6. Sex	7. Age (In yrs. last	birthday)	If Under 1 Year Months Days	If Under 24 Hr		ih ,	9. Birthplace (State or Forei		
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	r 28a	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Cour	ntry?	
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	ltems	Funeral	Arme	Decedent Ever in U.S. d Forces? 'es 2 ☐ No	13. V	Vas Decedent of His Yes, specify Cubai	spanic Origin? (n, Mexican, Pue	Specify Yes or No irto Rican, etc.)	- 14. Ra	ce - Americ ick, White,		
20	urs aft	þ	If Yes	Give or Dates:	1	☐Yes 25kNo	Specify:		Specia	'y: Wh	nite	
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	es 1 and 2 should b of Health and Ment: Item 27 is marked r other traumatic e		20a. Method of Disposition	20b. Place	e of Dispos	sition (Name of	1	Date	20c. Location	-		
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Baltimore,	permit. F Departme Importar any Injur		21. Signature of Funeral Service Licensee	parce	22.	Name and Addres	s of Facility			_		
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			23a. Part 1. Enter the disease, or complications to shock, or heart failure. List only one cause	on each line.				ac or respiratory a	rrest,		Approximate Interval Between Onset and Death	
	Physician /Medical		resulting in death)	herosclerotic		ovascular)isease					
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o.		ysic	1 Vac 3 No	regnant at time of death Inknown	n 5∐	Other (specify)						
<u>a</u> .	es that tigned by	by Ph	Part II. Dther significant conditions contributing	to death but not resultin	ng in the un	derlying cause give	n in Part I.	23e. Did t	obacco use con	tribute to th	ne cause of death?	
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E E	ysician: The l is certificate ha director, page							100 Yes	2 No	death?	2□ No	
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101	g Phy ter this neral d	n; To	27. Manner of Death 28a. [b. Time of	28c. Injury Work		28d. Describe			,,	
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Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detache	Certification;	data 1200.	Place of Injury - At home outlding, etc. (Specify)	, farm, stre	et, factory, office		City or To		ber or Rura	l Route Number,	
	spital nours neral / filled		29a. Certifier 1 Certifying Physician: T	o the best of my knowle	dge, death	occurred at the tim	e, date and pla	ce, and due to the	cause(s) and m	anner as st	ated.	
	the Ho in 24 I the Fu	Medical		the basis of examination manner stated.	and/or inv							
	vith To 1	2	29b. Signature and title of certifier			29c. License			29d. Date signe	· ·		
•			30. Name and address of person who completed		Ra) /Tunn		• Li •		March 1		JU#	
			LING LI. M.D	Construction (Item) 23		ll Penn S	treet.	Baltimore	e, Marv	Land :	21201	
	Sta			32. Registrar's Signature	9							
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DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygien 2004 08594 For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Year 2004 -biglia Sectram Morch /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Johns Hopkins Hospital Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) **Funeral** Months New York 087-22-4867 Director 74 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f ehow the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8439 Oak Bush Terrace 21045 **USA** Funerai filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 XNo 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 þ Yes Give 1 ☐ Yes 2 文No Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: "natural", Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry then Elementary/Secondary (0-12) College (1-4or 5+) Xray Technician Hospital 12 permit. Pages I and 2 should be filed Department of Health and Mental Hygie Importent: if item 27 Is marked other! eny injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Benjamin Birbiglia Gertrude Tuck 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty J. Birbiglia/Wife 8439 Oak Bush Terrace Columbia, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 3-17-04 Baltimore, MD 21. Signature of Funeral Service Liconsee Cremation Society of MD 299 Frederick Road Ba e de Thomas Gregor Baltimore, 21228 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Myocardial /Medical resulting in death) Due to (or as a consequence of): Examiner sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dabeks mellitus Due to (or as a consequence of). Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit 14 tus.ar and Due to (or as a consequence of): attending physician Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 □ Live birth 2 □ Fetal death
4 □ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Division of Vital Records, P.O. 1 ☐ Yes 2 ☐ No the 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 TYes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has autopsy performed 2 PNo 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Impatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Naturai 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident the within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide filled Hospitel 1 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 9 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) laura M. KES-000 march 16,2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32 MAR 1 8 2004 600 North SHEELE, mor buy Beltimory musing 297 32 egistrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 08595 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 1ERBERT Year BENT MARCH 5:30P M 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mariner Nursing Center Catonsville Baltimore If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplace (Stete or Foreign Country) **Funeral** 1⊠M 2□F 217-12-2933 80 Yrs **Director** Dec. 24,1923 Nebraska Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits , or items 23a or 28a-f show the Medical Exertiner must be notified at 1 ☐ Yes 2 ▼ No Maryland Baltimore Directo Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 313 Glenrae Drive U.S.A.

14. Race - American Indian,
Black, White, etc. 21228 filed within 72 hours after deeth by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 A Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Specify: White permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", any injury or other traumatic event, the Medical Example. 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 Businessman Vending 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Be James L. Bent May Platt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ethel Bent (Wife) 313 Glenrae Drive Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 ⊠ Burial 2 □ Cremation 3 □ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn Cemetery 3-17-2004 Woodlawn, Maryland 21. Signature of Funeral Service Licensee Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue Catonsville, Maryland 21228 23a. Rart1. Enter the disease, or complications that baused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheck, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS **Physician** /Medical Due to (or as a consequence of): Examiner PINOMVIND Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospitel or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Box 68760, attending physician by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 4☐ Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CARCINOMA 4 Mnknown PROSTATE 1 ☐ Yes 2 ☐ No 3 Probably Completed BRAIN umor. 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed) certificate 1□ Yes 2 X No after death.

Director: After this certific:
In by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Jursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Certification: To 27. Manaer of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 T Homicide within 24 hours a

To the Funeral C

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. the state of 29b. Signatura and title of certifier YSICIAN 29d. Date signed (Month, Dey, Year) tonin 2004. 42723. MARCH 8620 LIBERTY PLAZA MALL AVVERAHALLI 2113 RANDALLSTOWN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 1 8 2004

ORIGINAL

ASEMAN, MARIE

Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2004 08596 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Day **Physician** Marie A. Baseman MARC /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Hospice at Mercy Baltimore N/A If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) April 9,1919 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🖫 F 216-18-6209 84 Yrs. Director Maryland Usual Residence of Decedent death with the Meryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Merylan Depertment of Health and Mental Hygiene. Important: If item 27 ie marked other than "natural", or items 23s or 28s-f show any injury or other treumatic event, the Medical Examinat must be nothed at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1√Xes 2□No Maryland N/A Directo Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 2709 Hampden Avenue 21211 USA Funerai Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married ※ Married I∐Yes 27∭2No If Yes, Give 1 ☐ Yes X XNo Specify: Specify white φ 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Seamstress Maryland General 7th 18. Mother's Name (First, Middle, Maiden Sumame) Spital 17. Father's Name (First, Middle, Last) 89 George R. Gerwig 2 Augusta Simone 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Patricia A. Miller 1505 W. 36th Street Baltimore, MD 21211 (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) k☐kBurial 2 ☐ Cremation 3 ☐ Removal from State Moreland Memorial Pk 3/19 4 ☐ Donation 5 ☐ Other (Specify) Parkville, MD 21. Signatur Funeral Service Licenses $\stackrel{32.\,\text{Name and Address of Facility}}{\text{Burgee-Henss-Seitz Funeral Home,}}$ 3631 Falls Road Baltimore, MD 21211 Part1. Enter the distriction of that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use es the buriel-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Physician/Medical Due to (or as a consequence of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 20 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 28a. Date of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Netural 5 Pending 1 Yes 2 No efter death. 2 Accident investigation 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours eft To the Funerel Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D40854 3/16/2004 D 30. Namerand address of person who completed cause of deeth (Item 23a) (Type, Print) Riseber 106 Bultmer 21202 St Purl 31. Date filed (Month, Day, Year) MAR 1 8 2004 32. Registrar's Signature State Registrar

Division of Vital Records, P.O. Box 68760

ysiciai		State Registrar AMEND ITEM #5&1 1. Decedent's Name (First, Middle, Last)					BARNE	4	2. Date of Dea Month	Day	Yea	ar	I. Time of Death
l edica	1	4a. Facility Name (If not institution, give st	reet and number)			4h City 7	Town, or Location	on of Death	MARCH		County of D	-	11 - 7011
amine		THE TOHNS HOPKING !	+OSPITAL			-	MORE				N/A		
eral ctor		5 Social Security Number _ 6. Sex	7. Age	(In yrs. Ias 54	st birthday) Yrs.	If Under Months		der 24 Hrs. rs Min.	8. Date of Birt (Month, Day Sept. S	v. Year)		Country	e (State or Forei Virgini
	-	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Loc	ation						10d.	Inside City Limit
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nom	Directo	10e. Street and Number				10f. Zip	Code		T	10g. Citiz	ten of What	Country	?
	2	300 Edward Avenue	9				21090				U.S.		
other traumatic event, the Macingal Examiner must be notified at	by Funeral	11. Marital Status 1: 1 Never Married 2X Married 3 Widowed 4 Divorced	2. Was Decedent E Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates:		1	Vas Deced Yes, spec ☐ Yes 2	ent of Hispanic rty Cuban, Mexi		cify Yes or No- Rican, etc.)		I4. Race - A Black, W Specify:	/hite, etc	
	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)		16a. Decede (Give k	ent's Usua kind of wor OO NOT us	l Occupation k done during n e retired)	nost of workin	ng	16b. Kir	nd of Busine	ss/Indus	try
	E	Elementary/Secondary (0-12)	College (1-4or 5-	-)		vice				Se	ars		
	De C	17. Father's Name (First, Middle, Last)					18. Mo	other's Name	(First, Middle,	Maiden	Sumame)		
1	0	Henry Car	rruchi					Meli	issa Ba	rnes			
		19a. Informant's Name/Relationship (Typ		- 11		_	(Street and Nur						
		Laura Revere /Dau	ughter in				Avenue	, , , , ,	altimor				1227 21229
once.	-1	20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Re	moval from State	1	netery, crem						cation - City		_
		' 4 □Donation 5 □ Other (Specify)		Ceda			netery	3/15/					aryland
		21. Signature of Funeral Service License	· Xiac	ie t	9		d Address of Fa itchie		nce Fun y Bal				P.A. and 212
	1	23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	cations that caused	the death.	Do not ente	r the mode	e of dying, such	as cardiac o	r respiratory ar	rest,		A	oproximate terval Between
n		Immediate Cause (Final disease or condition	100616									0	nset and Death
I	1	resulting in death)	Due to (or as a	conseque	ence of):								Volay
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	Examiner	that initiated events c. resulting in death) Last	Due to (or a a										Vary
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	hysician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal o	death 3 🗌	Ectopic pro				4	23d. Date of Month	delivery Da	y Year
- 1	۵.	Part II. Other significant conditions conf	tributing to death bu	t not result	ting in the un	nderlying ca	ause given in Pa	art I.	23e. Did to	obacco u	se contribut	e to the	ause of death?
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	ompleted								24a. Was		24b. Were	autopsy	findings availa
Ш	E								perfo	rmed? 2 X No	deatl	h? Yes 2[
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	ှ	1 ☐ Yes 2 No	ospital: 1 Inpatier		RVOutpatient		the state of the s		me 5 Resid			Specify)	
	e o	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	Year) '	28b. Time of Injury	M	8c. Injury at Work? 1 ☐ Yes 2		28d. Describe I	now injur	y occurred		
	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubuilding, etc	ry - At hon . <i>(Specify)</i>	ne, farm, stre			-	28f. Location (S City or Tox			r Rural R	oute Number,
	edical C	29a. Certifier (Check only one) 2 Medical Examin		examination									
	Me	29b. Signature and title of certifier				290	. License numb	100		29d. Dat	e signed (M	fonth, Da	y, Year)
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		200000000	Land.			- 1			_	1	. 10	-1	

State of Maryland / Department of Health and Mental Hygiene [] [] [08598 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Yeer Month **Physician** 7:35 A. March 2004 William L. Brown, Sr. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 229 - 10th Street Anne Arundel Pasadena 8. Date of Birth (Month, Day, Y Dec. 29, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Year) **Funeral** Min. Months Days Hours 1**⊠**M 2□F 59 Dec. 1944 Maryland 218 42 6895 Director Usual Residence of Decedent death with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County wode / r then "natural", or items 23a or 28e-f sho the Medical Examinan must be notified at 1 □Yes 217 No Director Pasadena Maryland Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 229 - 10th Street 21122 U.S. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. filed within 72 hours after 1 X Yes 2 □ No If Yes, Give Viet Nam Year or Dates: 1 Never Married 2 Married Specify: White 21215-0036 1 ☐ Yes 2X No Specify: \$ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Engineer Westinghouse 4 years treumatic event, 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) and Mental F Pages 1 and 2 should be William Brown Mildred Thomas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 229 - 10th Street Itsm 27 i Diana Brown / Wife Pasadena, Maryland 21122 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 0 = b 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State permit. Page Department of Importent: If eny injury or once. Baltimore, Maryland 3/17/2004 Bayview Crematory A ☐ Donation _ 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee 4001 Ritchie Highway Baltimore, Maryland 21225 Approximate Interval Between Onset and Death 23a. Pan1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) MEtastaTic **Physician** /Medical Due to (or as a consequence of) MORE How **Examiner** 45 az Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (ur as a consequence of). Examiner or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □ Ectopic pregnancy Day Year jo in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4 Pregnant at time of death been signed by the a should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Certification; To Be Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy 1 ☐ Yes 2 ☐ No 1 Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Natural
2 Accident Division 5 Pending 1 ☐ Yes 2 ☐ No death. investigation filled in by the after death 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

— Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time. within 24 hours a

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completely filled To the Hospitel 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ed cause of death (Item 23a) (Type, Print) 30. Name and address of person who comple St 22 S (7RE 1204026 ٤

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

2. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 2001 08599 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month Bank **Physician** March 2:35 2004 16 iana /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore cokins Hospita n/a The Johns If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 □ M 2√2 F Yrs. may,29,1953 218-60-9312 50 Md Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10b. County 10a. State 28a-f show the Medical Examiner must be notified at 1⊠Yes 2□No Director Baltimore Md n/a 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number with Items 23a or U.S.A 14. Race - American Indian, Black, White, etc. 21205 deeth v Funeral 716 N. Linwood Ave. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "natural", or flent any injury or other treumatic event, the Medient Education 1 Never Married 2 Married Black 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify. Specify δ Year or Dates: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Calvin B. Scruggs Elementary/Secondary (0-12) College (1-4or 5+) 12th Secretary Funeral Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be George Fowlkes Lorraine Vaughan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 716 N. Linwood Ave. Balto. Md. 21205 Robert M. Banks/ husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition OwingsMills 1 ☑ Bunal 2 ☐ Cremation 3 ☐ Removal from State GarrisonForestVet.CemMarch23,2004 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service License CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO. MD 21213 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) years Reactive Airwa-Disease **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): P.O. Box 68760. the attending physician Physician/Medical as the IF FEMALE esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Day Year for L in the past 12 months?
1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by Division of Vital Records, director, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner?
1 N Yes 2 No 26. Place of Death (Check only one) Other: Hospital: 2 ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 3□ DOA 1 Inpatient Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred filled in by the funeral 27. Manner of Death After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation hours after death. 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospitel within 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ţ 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title-of certified 0 March 17, 2004 RES-GOD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MD 21287 voel Klein, MD. GOO N. Wolfe Street 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 8

DHMH 17 Rev 1/2001

ORIGINAL

		1	For State Registrar	State of Maryla		artment of Hertificate of E			iene 19. No. 2004	08600
			Decedent's Name (First, Middle, Las	1)				2. Date of Deat Month	h Day Year	3. Time of Death
K	Physicia	_	ROGER	H.	C	LARK	JR	· Harch	15 20dy	4 55 PM
	/Medic Examin	_	4a. Fecility Name (If not institution, give	street and number)		4b. City, Town, or	Location of De	eath	4c. County of Deat	h
		2	Good Samarita	u Hospital		Baltin	note		/	VA
	Funeral		5. Social Security Number 6. Se		. last birthday)	If Under 1 Year Months Days	If Under 24 H	Hrs. 8. Date of Birth Min. (Month, Day,	Year) 9. Birt	hplece (State or Foreign
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	the M 28a-f notifie	ect	10e, Street and Number	14	· · ·	10f. Zip Code	1 MO		Og. Citizen of What Co	ountry?
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	eath w	Funeral Director	11. Marital Status	HER STA 12. Was Decedent Ever in	U.S. 13.	Was Decedent of His		? (Specify Yes or No- uerto Rican, etc.)	14. Race - Ame	nican Indian,
	ter d	ᇤ	1 Never Married 2 Married	Armed Forces? 1XYes 2 ☐ No				uerto Rican, etc.)	Black, Whit	e, etc.
38	urs aft	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2. ♣No	Specify:		Specify: B	LACK
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B	be filed within 72 hours after death with the Maryland tal Hygjene. I al Hygjene. I dother then "neturel", or Items 23a or 28a-f show event, Itte Madical Examiner must be notified at	Be	17. Father's Name (First, Middle, Last)		1: "	011	18. Mother's	Name (First, Middle, I	Maiden Surname)	
Maryland	should I	ဥ	KOGER		CLA	PIR	HL	ICE	1 /4	-CR
<u>a</u>	2 sh and is m		19a. Informant's Name/Relationship	· · · · · · · · · · · · · · · · · · ·	19b. Maili	1		/	City or Town, State,	Zip Code)
	s 1 and 2 should be filed within of Health and Mental Hygiene. Item 27 is marked other then other traumatic event, the Mental Control of the Mental Contro		GLORIA DIXO	7 4 7	Place of Dispo	sition (Name of	TOUR	RTON ST	20c. Location - City or	Town, State
9	Pages 1 nent of H ant: If ite ary or ot		20a. Method of Disposition 1, Surial 2 ☐ Cremation 3 ☐	Removal from State	cemetery, crea	matory or other place	1		^	
Ē	Pa tmen tent:	١.,	* 4 □ Donation 5 □ Other (Specifi			ON FORE			DWINGS.	MILLS, MA.
Baltimore,	permit. Pages 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "netu any injury or other traumatic event, Ite Mudical ance.		21. Signature of Funeral Service Licer	A (IX) Olo		Name and Address	H.	BROWN	12 hora	10 21217
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			shock, or heart failure. List only	one cause on each line.	atii. Do not en	ter the mode or dying	g, 30011 a3 0a1	oldo or rospilatory arr	031,	Interval Between Onset and Death
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Вох	eath certifica attending pt for use as t	Z/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of preg		☐Ectopic pregnancy			23d. Date of de Month	livery Day Year
	ne deat the att hed for	SICIS	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time of 9 Unknown		Other (specify)			Mond	Day / oai
P.O.	es that the death cer igned by the attendir be detached for use	by Physician/Med	9 Unknown		and the standard	404 (00 00 00 00	- in Book I	22a Did to	bacco use contribute to	o the cause of death?
	ires tha signed I I be det		Part II. Other significant conditions					238. 010 10		robably 4 Hunknown
oro	w requir	ted	= 12d Stage New	ial Disease	1 +	1:	proce progr			
ec	e law has b je 2 sl	ompleted	Hy sothy roich	in , Colonal	y Milly	disease,	HTN	24a. Was a autops perfor	sy prior to death?	utopsy findings available completion of cause of
<u> </u>	: The	O						1 Yes	2 Z -No 1 Yes	2 2 HO
<u> </u>	ysicien: The lav is certificate has director, page 2	Be	25. Was case referred to medical examiner?	Hospital:	O 5 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7	other actions of the	20	Death (Check only or	ence 6 □Other (Spe	
ō	Phys rthis raldi	. To	1 Yes 2 400	28a. Date of Injury (Month, Day Year)	☐ ER/Outpatie 28b. Time o				ow injury occurred	icity)
5	iding Ph th. : After th funeral	to	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigatio	ſ	Injury		<br Yes 2 □ No			
Division of Vital Records,	Attending Physicien: The law requires that the death certifica rdeath. sctor: After this certificate has been signed by the attending phy the funeral director, page 2 should be detached for use as the	ertification:	3 ☐ Suicide 6 ☐ Could not be determined	ZDB. Flace of frilling - A	home, farm, st	reet, factory, office		28f. Location (S City or Tow	treet and Number or R	ural Route Number,
Ö	afte safte	Cert	4 Homicide	building, etc. (Spe	city)			Ony or You	n, State)	
	ospit hour unere ly fille	cal	29a. Certifier 1 Certifying Pl	nysician: To the best of my k	nowledge, dea	th occurred at the tim	ne, date and p	place, and due to the o	ause(s) and manner a	s stated. a to the cause(s)
	To the Hospitel or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	one)	and manner stated.					·	
	Son To	Σ	29b. Signature and title of certifier	15-Pi-	. 1	29c. License		1	29d. Date signed (Mon	
	UX,		- Mayou	- 11 lugitor	u ///	- 1	13 30		nach 13	2009
	9		30. Name and address of person who	completed cause of death (I	tem 23a) (Type	tan HOSDI	tap	Balting	March 15 och Ravel	21719
			31 Date filed (Month, Day, Year)	32. Registrar's Sig				Jul amor	- ,	7,031
	St Regist	ate rar	MAR 1 8 21	104 America	A. A.	Carlo I				

_			1 - For State Registrar	State of Marylan	d / Department o	f Health and M	lental Hygi		e. 04 08601
	Physic /Medi		Decedent's Name (First, Middle, Last, James B.	Croston			2. Date of Death Month March	Day Y	3. Time of Death 5:48 P M
	Examir	ner	4a. Facility Name (If not institution, give Gilchrist Hospice		4b. City, Tow Towso	n, or Location of Death		4c. County of Baltim	
	Funeral Director		214-22-3940	7. Age (In yrs. 81		ys Hours Min.	8. Date of Birth (Month, Day,) Aug. 5,	(ear) 9.	Birthplace (State or Foreign Country) Lest Virginia
	r 28a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Savage		y, Town or Location Howard				10d. Inside City Limits 1 ☐ Yes 2 ☒ No
3	death with the ms 23a or 28a	i Dire	10e. Street and Number 9104 Baltimore Str	eet	10f. Zip Cod 2076			g. Citizen of Wha United	
3/16/04@548pm nd 21215-0036	P 55 3	by Funeral Director		12. Was Decedent Ever in U. Armed Forces? 1-☑ Yes 2 ☐ No If Yes, Give Year or Dates:		of Hispanic Origin? (Spe Cuban, Mexican, Puerto		14. Race -	American Indian, White, etc. White
ं ऽप्© 215-0	within 72 hours after ene. than "natural", or Ita	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation s completed) College (1-4or 5+)	16a. Decedent's Usual Oc (Give kind of work do life. DO NOT use re	cupation ne during most of worki tired)	ng 16	6b. Kind of Busin	ess/Industry
3/16/아이 등 전 Maryland 21215-0036	TO 10 10 10 10 10 10 10 10 10 10 10 10 10	To Be Con	8 17. Father's Name (First, Middle, Last) James W. Croston		Store Manag	er 18. Mother's Name Virginia	(First, Middle, Ma	Grocery	Store
	s 1 and 2 should be filed if Health and Mental Hyg item 27 is marked othe other treumatic event,	-	19a. Informant's Name/Relationship (Ty) Alma V. Croston -		19b. Mailing Address (Streen 9104 Baltimo	eet and Number or Rura			
1748 Baltimore.	permit. Pages 1 and Department of Health Important: If item 27 any injury or other tr once.		20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ R 1 □ Donation 5 □ Other (Specify)		lace of Disposition (Name of pemetery, crematory or other partial downidge Mem.		ate 20	c. Location - City	
17 () () () () ()	Physician Imbor Medical		23a. Part1. Inter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)		to cellul	ufman Fune ington Blvc	eral Homo L. Elkri r respiratory arrest	At MMP dge, Mai	Approximate Interval Between Onset and Death
CH 16th 2007 8760, 2004	tificate be executed by the burial-transit as the burial-transit	licai Examiner	Securitially list conducts if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	ence of):				
og, MARC P.O. Box 687	ath cer ttendir or use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna. 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3 Ectopic pregnar			23d. Date of Month	delivery Day Year
TVesda ecords, P	w requi es that the de been signed by the a should be detached f	by	Part II. Other significant conditions con	tributing to death but not resu	lting in the underlying cause	given in Part I.	23e. Did tobac	·	e to the cause of death?
. 00	The far ate has bage 2	Completed					24a. Was an autopsy performed	prior death	autopsy findings available to completion of cause of 7.7 es 2 \(\subseteq\) No
AMES of Vital I	ysician: The is certificate his director, page	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital:	EB/Outpotent 2/7 DOA	26. Place of Death			
No.	To the Hospital or Attending Physician: within 24 hours after death. To the Funerel Director: After this centifica completely filled in by the funeral director,	ation: To	27. Manner of Death 1 Statural 5 ☐ Pending 2 ☐ Accident investigation		28b. Time of lnjury W	4 U Nursing Hom	ie 5 □ Residence 8d. Describe how i		pacify) (topice
ROSTON	vital or Att urs after de rel Diracto	Certification:	3 Suicide 6 Could not be determined		ne, farm, street, factory, offic		City or Town, S	tate)	Rural Route Number,
025	the Hosp in 24 hou the Fune pletely fi	Medical	(Check only one)	er: On the basis of examinati and manner stated.	on and/or investigation, in my	time, date and place, at opinion, death occurre	nd due to the caus d at the time, date	e(s) and manner and place, and c	as stated. fue to the cause(s)
	J. S. C.	2	29b. Signature and title of certifier	my Ale	Jours De	nse number	29d.	Date signed (Mc	onth, Day, Year)
<u> 11132</u>	10		<u> </u>	nplete cause of death (Item 3 M C 670(13a) (Type, Print) N. Charles	St. Cal	to md	2120	2
	Star Registra		31. Date filed (Month, Day, Year) MAR 1 8 2004	32. Registrar's Signat	sports				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3:00 PM **Physician** Inosencio D. Cavazos MARCH 2004 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Slen Burnie
If Under 1 Year | If Under 24 Hrs. NORTH ARMINDEL Arundel HOSPITAL Anne 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Min. 1 ★M 2 ☐ F Days Hours 457-58-9650 81 Dec. 28. Mexico Director Usual Residence of Decedent illed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Maryland Anne Arundel Glen Burnie Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 627 Binsted Road 21060 United States naturel', or Iteme 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ♣ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 🙀 Married 1 ☑ Yes 2 ☐ No Specify: Mexican Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) : 1 and 2 should be filed within Health and Mental Hygiene. tem 27 ie marked other than Elementary/Secondary (0-12) College (1-4or 5+) Field Laborer Agriculture 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be Benino Cavazos 2 Carpia Del Toro 19a. Informant's Name/Relationship (Type, Print) 19b, Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 is any injury or other traus Janie Radford - Daughter 614 Opel Road Glen Burnie, Maryland 21060 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 3/17/04 Elkridge, Maryland Meadowridge Mem. Pk. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gary L. Kaufman Funeral Home At MMP., Mgh 7250 Washington Blvd. Elkridge, Maryland 21075 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HEART CONGESTIVE FAILURE **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner death certificate be executed the attending physician and ned for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 99 1 Yes 2 No 3 Probably 4 Dúnknown Completed Deen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy performed? certificate 1 Yes a No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 No Inpatient ၉ 2 ER/Outpatient 3□ DQA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After To the Hospital or Attending Injury 1/2/Natural 5 Pending death. 1 Yes 2 No 2 Accident investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) à 4 Thomicide hours after within 24 hours a To the Funeral D 🕼 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00055973 MB MARCH 14, 2004 kassa Lun seleke 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11500 SUTHERLAND SILVER SPRING MD 20904 DE SSE WAY 2ELEKE HILL 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 8

10		30. Name and address of person who call the state of the	IE ST. BALT	IMORE	Print) MD 213	201				
		1/NC	75.41 M	<u> </u>		1643		HAR. 12	- z	004
To the P within 24 To the F complete	Med	one) 29b. Signature and title of certifier	and manner stated.		29c. Licen	se number		29d. Date signed	(Month, E	Dey, Year)
To the Hospital or within 24 hours aft To the Funeral Diccompletely filted in	edical Co	(Check only 2 Medicel Exam	sician: To the best of my kiner: On the basis of exami							
Atten ar deat ector: by the	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spe	Unknown home, farm, str cify)	1	1163 24110	28f. Location (Street and Number or Rural Re City or Town, State)			
fing Afte fune	tion;	27. Manner of Death Talkatural 5 ☐ Pending investigation	28a. Date of Injury (Month, Day Yeer)	_	28c. Inju Wo	ryat ork?]Yes 2 X]No		how injury occurr		e o mu
Physician: this certific ral director.	2	1 ≥ Yes 2 □ No	1 Inpatient 2		3 DOA		Home 5 Resi)
sician: The l certificate ha rector, page	Be Co	25. Was case referred to medicat examiner?					1⊠ Yes eath (Check only o		☐ Yes	2 □ No
aw Is b	Completed							psy promed? d	rior to com	sy findings available appletion of cause of
requires that the elem signed by the hould be detached	þ	Part II. Other significant conditions co	ntributing to death but not r	esulting in the u	nderlying cause gr	ven in Part I.		obacco use contr Yes 2⊠No		e cause of death? ably 4 Unknow
death certif s attending d for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of preg 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	etal death 3	Ectopic pregnance Other (specify)	A WON THE .		23d. Date Mor	e of deliver	ry Day Year
icate be executed physicien and s the burial-transit	edical Examin	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	equence of):	11	Lodo	M & EXAMINA	J mol		
/Medical Examiner	er	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Einter Underlying	Due to (or as a conse	equence of):	7		plicatin l Therap			
		23a. Part1. Enter the disease, or compleshock, or heart failure. List only o	ications that caused the de ne cause on each line.	ath. Do not ent	er the mode of dyi	ng, such as cardi	ac or respiratory a	rrest,		Approximate Interval Between Onset and Death
permit. Page Depertment o Importent: If any injury or once.	Ì	21. Signature of Funeral Service Licens		22	. Name and Addre	ess of Facility	onaldson e, Laure	Funeral	Home	e, P.A.
Pages 1 a nent of He int: If Item iry or othe		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	-	sition (Name of natory or other pla 1 Cremat	1	Date 4/2004	20c. Location - Odenton,		wn, Stete
ges 1 and 2 should be filed within to f Health and Mental Hygiene. If Item 27 is marked other than or other traumatic event, the Meres of the files		Paul W. Clark, Jr.			•		olumbia,			·
should be nd Menta marked umatic ev	5	Paul W. Clark 19a. Informant's Name/Relationship (T)	rpe, Print)	t 9b. Mailin	ng Address (Street		ces Smit		State, Zio	Code)
be filed vital Hygie d other i	Be	17. Father's Name (First, Middle, Last)					ime (First, Middle	, Maiden Sumam		
	Completed	Elementary/Secondary (0-12) 12th	Cottege (1-4or 5+)	life. L	oo NOT use retire	id)		Depar	tmen	t Store
72 hours after natural', or Ite dical Examine	eted by	3 Widowed 4 Divorced 15. Decedent's Edu (Specify only highest grad	Year or Dates: cation e completed)	(Give	lent's Usual Occu kind of work done	during most of w	orking	16b. Kind of Bu		
172 hours after death with the Marylan "natural", or Items 23a or 28e-f show colcal Examiner riunt be notified at	교	11. Marital Status t Never Married 2 Married	t2. Was Decedent Ever in Armed Forces? t ☐ Yes 2 ☑ No If Yes, Give		Vas Decedent of I f Yes, specify Cub		Specify Yes or No rto Rican, etc.)	Blac	e - America k, White, e Whi	etc.
h with 23a or	al Dir	6622 Allview Driv	7e		2104	.6		US		,.
death with the Maryland ms 23s or 28e-f show	Director	MD Howard 10e. Street and Number		Columbia	10f. Zip Code			10g. Citizen of V	/hat Count	1 ☐ Yes 2 ☐ No
yland	-	Usual Residence of Decedent t0a. State 10b. County	10c. 0	City, Town or Lo	cation				10	d. Inside City Limits
Funeral Director		174-40-2624	IM MOF	66 Yrs.	Months Days		. (Month, De	27 1947		ace (State or Foreig try) W York
		UNIVERSITY OF MARYLAN 5. Social Security Number 6. Sec		EN TER s. last birthday)	BALT IN		s. 8. Date of Bir	th	9 Righal	ana (State or Foreig
Examin		KATHLEEN CLARK 4a. Fecility Name (If not institution, give			4b. City, Town, o	or Location of Dea		4c. County	-	16 (0)
/Medic							HAR	12 2	004	12:43 N

DHMH 17 Rev 1/200t

			For Stete Registrar	State of Ma	ryland	/ Depa	rtment of F tificate of	lealth a Death	and Me	ental Hy	giene Reg. No	2004	08604
	Physicia	ın	1. Decedent's Name (First, Middle, Last, Louise S. Co	ckey						2. Date of De. Month	Da	y Year	3. Time of Death 1:40 A M
	/Medic Examin	al :	4a. Facility Name (If not institution, give				4b. City, Town, o	r Location o		March		2004 County of Death	
120	LAdillin	٠.	Edenwald Nursing				Towson	T-W11-1-	0.411		_	Baltimor	e
40 Ат	Funeral Director		213 10 0230	X 7. Age	(In yrs. las	t birthday) Yrs.	Months Days	If Under Hours		B. Date of Birl Month, Da APR I	, 19	11 Mary	nplace (State or Foreign intry) 1 Land
7	land		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Loc	ation						10d. Inside City Limits
7	Mary a-f she	tor	Maryland Baltimor	e	Tows	on							1 ☐ Yes 2√7 No
3/16/04	death with the Maryland ms 23a or 28a-f show	Director	10e. Street and Number				10f. Zip Code				10g. Ci	izen of What Co	untry?
2/16	eath w	Funeral	800 Southerly Roa	d 12. Was Decedent Ev	ver in U.S.	13. V	21286	lispanic Orig	gin? (Spec	ifv Yes or No	<u>USA</u> -	14. Race - Amer	icen Indian,
	be filed within 72 hours after death with the Marylan lal Hygiene. Id other then "natural", or flems 23a or 28a-1 show event, the Marical Examiner must be notified at	۾	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:			/as Decedent of H Yes, specify Cuba ☐ Yes 2 No	Specify:	n, Puènto R	ican, etc.)		Black, White Specify:	White
5-0036	72 hou	eted	15. Decedent's Edu (Specify only highest grad	ication le completed)		16a. Deced	ent's Usual Occup kind of work done O NOT use retired	ation during most	t of working	9	16b. K	ind of Business/l	ndustry
5.	within ene. then *	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	-)	Homen		d)			Ow	n Home	
	should be filed within and Mental Hygiene. marked other then matic event, the M	Be C	17. Father's Name (First, Middle, Last)					18. Mothe	er's Name (First, Middle,	Maiden	Sumame)	
Lowise	should band Ments and Ments marked	2	Wiley W. Smith						en Gro		0.11		
Mar	d 2 cd 2		19a. Informant's Name/Relationship (T) Frances C. Sampso				g Address <i>(Street</i> Genoes Po						19 Code) 13462
je ,	es 1 and of Health If Item 27 or other to		20a. Method of Disposition				ition (Name of atory or other place		Da			ocation - City or 1	
cKey, Baltimore,	nit. Pages artment of ortant: If it injury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify)		1	co Cre	ematory 1	nc.	3 - 16-			timore,	MD
eckë Baltin	permit. Pag Department Important: I any injury o		21. Signature of Euneral Service Licens Inomas Gregor			C1 22	Name and Addre emation 99 Freder	ss of Facilit SOCIE ick R	ty of Road	MD, Báli	Inc.	re, MD	21228
-UK (88760)	/Medical Examiner be executed // // // // // // // // // // // // //	edicai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlyinu, Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a b. Due to (or as a c. Due to (or as a d.	de	June	ul levet	Jen Ler	entr de	sean			Interval Between Onset and Peath Surveys
P.O. Box 68	eath certifi attending for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome o 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	2 ☐ Fetal d	eath 3	Ectopic pregnancy Other (specify)	/				23d. Date of deline	very Day Year
	uires that signed b	ρ	Part II. Dther significant conditions co	ntributing to death but	t not resulti	ing in the un	derlying cause giv	en in Part I.		23e. Did to		1/	the cause of death?
Division of Vital Records,	The law requir sate has been si page 2 should l	Completed									sy rmed?_	prior to c death?	opsy findings available ompletion of cause of
ital	iclen: The certificate rector, pag	Be C	25. Was case referred to medical					26. Place	of Death (1 □ Yes (Check only o	2 /2 No me)	10 105	2 NO
of V	ding Physiclen: h. After this certific funeral director,	2	examiner? 1 Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpatien 28a. Date of Injury		VOutpatient		NU		e 5 Resid		6 Other (Spec	ify)
o	Attending F r death. sctor: After by the funera	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day	Year)	Injury	28c, Injur Wor M 1 🗆	k? Yes 2 □ I		d. Describe i	1014 11110	ly occurred	
ivisi	or Attendi after death. Director: A in by the fu	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injur	ry - At hom (Specify)	e, farm, stre	et, factory, office		28	3f. Location (S City or Tox			ral Route Number,
۵	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the			rsicien: To the best of iner: On the basis of e									
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	F 3 F 8		1/	m	w	m	0	29	7 6	9	Mar	rch 16,	2004
_	70		30. Name and address of person who c	popleted calue of de	ayn (Item 2	(Type, I	Print)	W.	L.	1/100	1	& Bu	Its Us
	Sta Registr		31. Date filed (Month, Day, Year)	32 Registra	r's Signatui	TB And	alle)		<i>v v</i> /	1		-	41118

State of Maryland / Department of Health and Mental Hygiene 0 0 08605 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 45M Year **Physician** RUTH COHER MARCH 2004 /Medical ATU 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner House I Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Months Days Hours Min. JULY 30,1919 Nonta JUST NIAL GENIER BALTMONE 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 □ F Director 216-01-8330 84 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits wat by rectified at 1 ☐ Yes 2 ☑ No Director BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7920 SCOTTS LEVEL ROAD 21208 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify. WHITE other traumatic event, it is Mudical Exam 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CLERK SOCIAL SECURITY ADMIN. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Health and Mental I KLEIN ပ TURKOFF 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MEREL KAUZLARICH / DAUGHTER 1713 LAUTERBACH ROAD - FINKSBURG, MD 21048 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State ö 4 ☐ Donation 5 ☐ Other (Specify) BNAI ISRAEL CEMETERY 3/16/2004 BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the direase, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician MYCEARDIAL INTARETIC /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and the burial-transit Due to (or as a consequence of): Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? for Day P.O. I 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? putllitus autopsy performed ACC. DIN 1 ☐ Yes 2 ☐ No 1 ☐ Yes Division of Vital 2 ₽No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending after death. Director: A 1 □ Yes 2 □ No investigation 2 Accident completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, Jarm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours at To the Funeral D Hospital 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 19502 MANIH 15, 2804 au) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PANDAILETONA MANGEND 21132 B. CENTRAN OR14NDO 6-32. Registrar's Signature 31. Date filed (Month, Day, Year) MAR 1 8 2004 Registrar

Harold R. Coulter

VOID

CERTIFICATE

2004-08606

SEE

CERTIFICATE #

2003 - 44486

			1 - For State Registrar	State of Ma	ryland / I	Depart Certi	ment of H ficate of L	ealth and M Death	lental Hy	giene 20	04 086	07		
2 1/32	Dhysisi	0.0	Decedent's Name (First, Middle,	Last)			`		2. Date of De. Month	ath	3. Time of Dea	ath		
	Physici /Medio		G9-1991			1	eene		March	15, 20	04 5,45 1	M		
	Examir	er	4a. Facility Name (If not institution,	11 .	/	4	011	Location of Death	uland	4c. County o	f Death			
	Funeral		5. Social Security Number		(In yrs. last bi		Under 1 Year	orc //ar If Under 24 Hrs.	8. Date of Birt	th	9. Birthplace (State or Fo	oreign		
6.	Director		232-48-6949	¹X™ 2□F 72	2	Yrs.	lonths Days	Hours Min.	(Month, Da 1-18-3	32 (32)	W. Va.			
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	wn or Locat	ion				10d. Inside City L	imits		
	Maryli f sho	or	Md. NA		•	Baltin				X☐Yes 2☐I				
	r 28a-	Director	10e. Street and Number	•			10f. Zip Code			10g. Citizen of Wi	hat Country?			
	th with		5406 Catalpha	Rd.		21214					A			
	tams	ner	11. Marital Status	12. Was Decedent E Armed Forces?		13. Wa	Decedent of His	spanic Origin? (Spo n, Mexican, Puerto	ecify Yes or No Rican, etc.)		- American Indian, , White, etc.			
36	rs afte	y F	1 ☐ Never Married 2 ☐ Marrie 3 ☑ Widowed 4 ☐ Divorced	ed 1 ⊡Yes 2 X No If Yes, Give Year or Dates:	0	1 🗆	Yes 💥 No	Specify:		Specify:	Black			
21215-0036	filed within 72 hours after death with the Maryland Hygiene. yther than "natural", or items 23a or 28a-1 show sht, the Medical Examene must be notified at	Completed by Funeral	15. Decedent	s Education	16a	a. Deceden	l's Usual Occupa	ition		16b. Kind of Bus	iness/Industry			
215	thin 7.	npie	(Specify only highest Elementary/Secondary (0-12)	College (1-4or 5-	+)		d of work done d NOT use retired;	luring most of work)	ing					
7	ygien ygien her th		10th grade			Coke	Oven	40.44.45.1.41	/51 - A414 #	Sparrov				
Maryland	ntal H	Be.	17. Father's Name (First, Middle, L	ast)				18. Mother's Name			oker			
2	Should nd Me mark imatic	၉	James Deener 19a. Informant's Name/Relationsh	ip (Type, Print)	198	b. Mailing A	Address (Street a	and Number or Rura						
	alth a		Brenda Deener	Daught	er !	5406	Catalpha	a Rd., Ba	ltimore	Md. 2	1214			
ore,	of He of He fitem r othe		20a. Method of Disposition 1	3 Pamoval from State	20b. Place of	of Disposition			Date		city or Town, State			
Ĕ	Pag Iment Iant: I		* 4 Donation 5 ☐ Other (Sp	ecify)	Arbi		Mem. Pk.	3–19	-04	Arbutus	, Md.			
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "neturef", or items 23e or 28e-1 show amportant: If item 27 is marked other than "neturef", or items 23e or 28e-1 show any injury or other traumatic event, the Medical Example in must be notified at ODGE.		21. Signature of Funeral Service L	icensee			ame and Addres rch F.H.		Balt 1101 E	imore, Mo . North	d. 21202 Ave.			
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Peath											
	Physician		Immediate Cause (Final disease or condition	_ Seps	515						Onset and Deat	.th		
	/Medical Examiner		resulting in death)	Due to or as a	consequence	of):								
		e.	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence	of):						_		
	d d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events											
Ó	exectan an arrial-tr	Еха	resulting in death) Last	Due to (or as a	consequence	of):								
8760,	cate be executed physician and the burial-transit	dicai		d					·.					
9	eath certific attending p	0	IF FEMALE:	23c. If yes, outcome of	of pregnancy					22d Date	of delivery			
Вох	The law requires that the death certificate has been signed by the attending tage 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 ☐ Live birth 2 4 ☐ Pregnant at t	2 Fetal death	Fetal death 3 Ectopic pregnancy					th Day Year	r		
Ö.	that the de led by the a detached f	hysi	9 Unknown	9□ Unknown										
S,	res tha igned be det	by P	Part II. Other significant condition	ns contributing to death but	t not resulting i	in the unde	riying cause give	n in Part I.			oute to the cause of death			
ord	w require been si should I	ted	Encl Stage	Kev14/ 1015	45C				101	/es 2 □ No 3	3 ☐ Probably 4 ☑ Unkr	nown		
Records,	hasb ge 2 st	Completed	Vighetes in	10/1/05					24a. Was autop	osy pri	ere autopsy findings avail ior to completion of cause	ilable e of		
			Coronary Ar	tery Vises	50				1 Yes	2010 10	ath? Yes 2 No			
₹	sicial certificacto	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	nt 2□ER/O	utnationt	3 DOA Othe	26. Place of Death		ne) dence 6 🗆 Other	(Const.)			
o	Attending Physician: ir death, ector: After this certifica by the funeral director.	-	27. Manner of Death	28a. Date of Injury	28b.	Time of Injury	28c. Injury Work	at at		now injury occurred				
joi	tending F leath. tor: After the funera	atio	1 Unatural 5 Pending 2 Accident investig	ation	(dai)			r res 2 □ No						
Division of Vital	or Attendate death Director:	Certification;	3 Suicide 6 Could n 4 Homicide determine	ot be ned 28e. Place of Injur- building, etc.	ry - At home, fa . (Specify)	arm, street	factory, office		28f. Location (5 City or Tox		r or Rural Route Number,			
	To the Hospital or Attend within 24 hours after death To the Funeral Director: . completely filled in by the f	edical C	29a. Certifier 1 Certifying (Check only one)	3 Physician: To the best of examinar: On the basis of and manner state	examin <i>a</i> tion ar	ge, death or nd/or inves	curred at the tim tigation, in my op	e, date and ptace, ininion, death occurr	and due to the e	cause(s) and mani date and place, an	ner as stated. Indidue to the cause(s)			
	Fo the within Fo the comple	Med	29b. Signature and title of certifier	d I I			29c. License	number		29d. Date signed	(Month, Day, Year)			
)	->-0		Markad a	· William	M.D.		Doc	03896	4	March	15, 2004	ř		
	10		30. Name and address of person v	who completed cause of de	ath (Item 23a)	(Type, Prin	nt)	11	1 1	1: 111	12 1			
	Y		31. Date filed (Month, Day, Year)	Ven Blvd, 18 32. Registra	15c/tim	iore /	40, 212	239. Mi	chael f	t. Wilso,	n M.D.			
	Sta Registr		MAR 1 8 200	49	H.	and)								

			1 - For State Registrar	State of Marylar		artment of F			giene 0 0	4 08608
I	Physici /Medic		1. Decedent's Name (First, Middle, La.	DAVIS				2. Date of Dea		(ear 2 10 PM
	Examir	ier	4a. Facility Name (If not institution, give	street and number)		City, Town, o	Location of Death	>	4c. County of	
	Funeral Director		5. Social Security Number 6. S 216-36-9465	ex 7. Age (In yrs. Kim 2□F 61	last birthday Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Apr 6,). Birthplace (State or Foreign Country) aryland
	Maryland f ahow	ō	Usual Residence of Decedent 10a, State 10b. County MD	10c. Ci	ity, Town or L	ocation altimore			***	10d. Inside City Limits 1 √√ Yes 2 □ No
	or 28a-	Direct	10e. Street and Number			10f. Zip Code			10g. Citizen of Wha	at Country?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Mportant: if Item 27 Is marked other than "natural", or Items 23e or 28e-f ahow my njury or other traumatic event, its Medical Examina must be notified at NDCB.	by Funeral Director	612 Pulaski Stre 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1	J.S. 13.	Was Decedent of H If Yes, specify Cubs 1 ☐ Yes 2 ☒ No	1223 dispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	USA 14. Race - Black, Specify:	American Indian, White, etc. black
21215-0036	in 72 hou n "nature Vedical E	Completed	15. Decedent's E (Specify only highest gra		(Give	edent's Usual Occup a kind of work done DO NOT use retired	during most of work	king	16b. Kind of Busin	ness/industry
d 212	s 1 and 2 should be filed within if Health and Mental Hygiene. Item 27 is marked other than other traumetic event, the Mental traumetic event.		Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last,	0].	handyman	18. Mother's Nam	ne (First, Middle,	Va1 Maiden Sumame)	rious
Maryland	should be ind Mental marked o	To Be	George A. Dav	ris			l		h Jacksor	
Man	and 2 sho ealth and n 27 ls m		19a. Informant's Name/Relationship (Betty Pollard/si			ing Address <i>(Street</i> E. Park A				
Baltimore,	Pages 1 ar nent of Hea int: if Item		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specif	Removal from State	Place of Disp cemetery, cre	osition (Name of ematory or other place		Date	20c. Location - Ci	ty or Town, State
Balti	permit. Page Department of Important: if any injury or once.		21. Signature of Fineral Service Licer Ronal d S		r Š	2. Name and Addre tate Anat altimore,	omy Board MD 2120	1 655 W.	Baltimo	re Street
760,	Francisco Assistance Asistance Assistance Assistance Assistance Assistance Assistance As	ical Examiner	23a. Part. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infiliated events resulting in death) Last	c	quence of):	Staphy US all	./	T.	e .	Approximate Interval Between Onse ind Death
P.O. Box 687	death certifica e attending ph d for use as th	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes No 9 Unknown	23c. If yes, outcome of pregn 1 Live birth 2 Fet 4 Pregnant at time of	al death 3	□Ectopic pregnancy	у		23d. Date of Month	
	quires that in signed b uld be det	by	Part II. Other significant conditions of	ontributing to death but not re	sulting in the	underlying cause giv	ven in Part I.	23e. Did to	1	ute to the cause of death?
Vital Records,	ysician: The iaw requires that the is certificate has been signed by the director, page 2 should be detached.	Completed	Acute	bitis Deval +	al	uro.		24a. Was a autop: perfor Yes	sy prio med? dea	ore autopsy findings available for to completion of cause of ath? Yes No
o	Jing Ph I. After th funeral	ation; To Be	25. Was case referred to medical examiner? 1 Yes No 27. Manner of Death 1 Natural	28a. Date of Injury (Month, Day Year)	ER/Outpatie 28b. Time Injury	of 28c. Injur Wor	4 Italishing Inc	ome 5 Resid	ne) ence 6 Other ow injury occurred	
Division	al or Attandi s after death. si Director: A sd in by the ft	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Spec	nome, farm, s ify)	treet, factory, office		28f. Location (S City or Tow		or Rural Route Number,
	To the Hospital or Attand within 24 hours after death To the Funeral Director: completely filled in by the	edical		nysician: To the best of my kn niner: On the basis of examin and manner stated.						
	To the To the comp	M	29b. Signature and title of certifier	20 man and	0	29c. Licens	27-16	3	29d. Date signed (Wonth, Day, Year)
			30. Name and addless of person who	completed cause of seath (Ite	m 23a) (Type	Print)	Sollar	2000) West	BAHamoro
	Sta		31. Date filed (Month, Day, Year) MAR 1 8 2	32. Begistrar's Sign	nature	best	· · · · · · · · · · · · · · · · · · ·			

State of Maryland / Department of Health and Mental Hygiene and a

		•	For State Registrar	State of Maryland /		cate of D		Re	g. No.	4 08609
	Diam'r.		Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Ye	
	Physicia /Medic		Gertrude Dorothy	Dilworth				March 10	2004	4:10 AM M
	Examin		4a. Facility Name (If not institution, give str		4b.	City, Town, or L			4c. County of D	
			4417 Slate Ridge		6 interes is 161	Whitef	ord If Under 24 Hrs.	8. Date of Birth	Harford	
h	Funeral Director		137-20-2407	7. Age (In yrs. last 81			Hours Min.	Month, Day, Aug 18,	Year) 1922 N	Birthplece (State or Foreign Country) Iew York
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	own or Locatio	n	-			10d. Inside City Limits
	Mary -1 sho	ţ	MD Baltimore		White	Eord				1 ☐ Yes 2½ No
	3s or 28s	ii Direc	10e. Street and Number 4417 Slate Ridge	Road	10	Of. Zip Code	21160	10	g. Citizen of What USA	
36	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or Items 23s or 28s-1 show any injury or other traumatic event, the Modical Examinar must be notified at ance.	by Funeral Director	11. Marital Status 12 Married 3 Widowed 4 Divorced	. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		7.7	panic Origin? (Sp Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		umerican Indian, Vhite, etc. White
Ö	2 hou	ted	15. Decedent's Educa (Specify only highest grade of	ition 10	6a. Decedent's	S Usual Occupati	on ring most of work	ina 1	6b. Kind of Busine	ess/Industry
Maryland 21215-0036	ithin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)			ring most of work	,,,,	1 .	
2	led w lygier her th	ဝ	17. Father's Name (First, Middle, Last)	6	tead		9 Mother's Nam	e (First, Middle, M	educat	lon
and	I be fi	Be	Francis Xavier	McRorie		'		Ellen Ca		
Ž	should ad Me mark matic	은	19a. Informant's Name/Relationship (Type		19b. Mailing Ad	ddress (Street an		al Route Number,		te, Zip Code)
<u>8</u>	nd 2 s lith ar 27 is r trau		Timothy Sullivan		915 Whe	eel Road	Bel Air	, MD 21	015	
Baltimore,	Pages 1 a lent of Hea nt: If item iry or othe		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Rei 4 ☒ Donation 5 □ Other (Specify)	moval from State	e of Disposition etery, cremator	n (Name of ry or other place)		Date 2	0c. Location - City	or Town, Stete
Balti	permit. Departm Importe any inju		21. Sign fun of Euneral Service Licensee	add life tor	Stat Balt	me and Address e Anato imore, l	of Facility my Board MD 2120	₁ 655 W.	Baltimor	e Street
	-<		23a. Part1. Enter the disease, or complications shock, or heart failure. List only one	ations that caused the death. E						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	172611	mirs	T.	(min)	XII		Ordet and Death
	/Medical		resulting in death)	Due to (or as a consequent		- 1				
835	Examiner	L	Sequentially list conditions, b.	2 4-7	4)					
	ed isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequent	ice of);					
•	tificate be executed ig physicien and as the burial-transit	xan	that initiated events c. resulting in death) Last	Due to (or as a consequent	ice of):					
68760,	sicier b buria	SalE	L _d							
687	ificate g phy as the	edic	u.							
.O. Box	death cer e attendir od for use	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 N No 9 ☐ Unknows	the contract of the cont	ath 3 Ecto	opic pregnancy ner (specify)			23d. Dale of Month	delivery Day Year
₾.	hat th	Ph	Part II, Other significant conditions conti	ributing to death but not resulting	na in the under	vino cause given	in Part I.	23e. Did tob	acco use contribut	te to the cause of death?
rds,	w requires tha been signed should be det	ed by						1 □ Ye	s 2 No 3	Probably 4 Unknown
Record	e ia has je 2	Completed						24a. Was an autopsy perform	prior	
Vital		0	25. Was case referred to medical				26. Place of Dear	h (Check only one	74	
_	8 F	ToB	examiner? 1 Yes 2 No Ho		VOutpatient 3	DOA Other	4 Nursing H	ome 5 Resider	nce 6 Other (Specify)
n of	ng Pł		27. Magner of Sath 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	Bb. Time of Injury	28c. Injury a Work?		28d. Describe ho	w injury occurred	
<u>s</u>	Attending r death.	cati	2 Accident investigation 3 Suicide 6 Could not be	CO. Place of leive. At home			BS 2 □No	291 Location (Str	ant and Number o	r Rural Route Number,
Division	al or At after i Direc d in by	Certification;	4 ☐ Homicide determined	28e. Place of Injury · At home building, etc. (Specify)	s, tarm, street,	factory, office		City or Town		ADIA ADDIO NUMBER,
	To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral (ledical C		cian: To the best of my knowle er: On the basis of examination and manner stated.						
	To the within To the comple	Me	29b. Signature and title of a rtifier	11		29c. License		29	d. Date signed (M	fonth, Day, Year)
			· NN	MD		23	4052	1	Binch 11.	2004
			30. Name and address of person who con	npleted cause of death (Item 23	3a) (Type, Prin	"th Av	inul	BIL AN	Mary	2004 land 21014
N	Sta	ate	31. Date liled (Month, Day, Year)	32 Registrar's Signature	θ 🥒	•				

Registrar

State of Maryland / Department of Health and Mental Hygienes of

					Ce	ertificate of	f Death	rivientarri	Reg. No.	104	08610
	Physic	ian	1. Decedent's Name (First, Middle, La		77.71	1.0		2. Date of D Month		Year	3. Time of Death
. 1	/Medi	cal	IRVING C	HARLES	DAI	115	# 6'1 *	03	14	04	2012
j.	Exami	ner	McCready Hospit				Crisfiel	or Location of Dea		nerset	
	Funeral		5. Social Security Number 6. S	Sex 7. Age (In	yrs. last birthday	y) If Under 1 Year	r If Under 24 Hr				ace (State or Foreign
	Director		214-70-4328	⊠ м 2□ F 7	9 Yrs.	Months Days	B Hours Mir	n. (Month, D. Nov 1	rth ay, <i>Year)</i> 1924	Mary.	ace <i>(State</i> or Foreign Land
	and		Usual Residence of Decedent 10a. State 10b. County	100	. City, Town or L	ocation				10	d. Inside City Limits
	Maryl f sho	ğ	MD Somer			field				100	1 ☐ Yes 24☐ No
	h the	irec	10e. Street and Number			10f. Zip Code			10g. Citizen of	f What Countr	
	23a c	Funeral Director	201 Hall Hgwy				21817		US		
	er dez	n n	11. Marital Status	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☒ No	n U,S. 13.	. Was Decedent of If Yes, specify Cub	Hispanic Origin? (ban, Mexican, Pue	Specify Yes or Norto Rican, etc.)	o- 14. Ra	ace - Americar ack, White, et	
20	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "netural", or items 23s or 28e-f show event, the Medical Exertine must be rotified at	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 🔼 No If Yes, Give Year or Dates:		1 ☐ Yes 2X No				ity: whit	
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7	iled w Hygier her th	ပ်	11		í	farm hand				ulture	
yland	T - 6	Be	17. Father's Name (First, Middle, Last) Charles Davis					^{ame (First, Middle} May Dais		me)	
	should nd Men marke	၉	19a. Informant's Name/Relationship (Type, Print)	19h Mail	ing Address (Stree				State 7's C	15 -fs l
Z	tra		Lois McDaniel/au			9 Higman				i, State, Zip C	20 0 (9)
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6			23a. Part . Enter the disease, or comp shock, or heart failure. List only	blications that caused the done cause on each line.	eath. Do not en	ter the mode of dyi	ng, such as cardia	c or respiratory a	rrest,	A In	pproximate nterval Between
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	ine law requires that the death cereite has been signed by the attendin page 2 should be detached for use	Physician/	Part II. Other significant conditions co	ntributing to death but not i	esulting in the u	inderlying cause giv	en in Part I.	23b. Did t	obacco use co	ntribute to th	e cause of death?
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	r nysician: r this certifice aral director, p	P	examiner? 1 ☐ Yes 2, No	Hospital:	☐ ER/Outpatien	nt 3 DOA Oth	0.5	lome 5□ Resid		er (Specify)	
	σ σ Ψ	<u>ë</u>	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor	y at k?	28d. Describe h			
	death death stor: /	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	290 Place of Injury At	hama form at-		Yes 2□No	006 1 // (0			
	after Bire d in b	Certification:	4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spe	cify)	eet, lactory, office		28f. Location (S City or Tow	rreet and Numb n, State)	er or Hurai Ho	ou <i>te Number</i> ,
9100	hours hours in fille		29a. Certifier 1 Certifying Phy (Check only 2 Medical Exami	sician: To the best of my k	nowledge, death	occurred et the tim	ne, date and place	, and due to the c	ause(s) and ma	inner as state	d.
1	vithin 24 hours after death. To the Funerel Director: Aft completely filled in by the further function.	Medicai	one)	ner: On the basis of exami and manner stated.	nation and/or inv	estigation, in my op	pinion, death occu	rred at the time, o	ate and place,	and due to the	e cause(s)
Ē	2 × 6	2	29b. Signature and title of certifier	118 00	70	29c. License			9d. Date signer		
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		1	od. Name and oddress of person who or GREGORIO M. B.				zepov t	DO GAL	102000	/ Wn	7 1601
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	Registra	ar	MAR 1 8 2004	38. Registrar's Sig	or Agos						

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [08611 For State Registratement #23b&c PER PHY G829 3/18/Qertificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) MARCH 11,2004 Year **Physician** John P. Dickens, Jr. 2:45 P M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner VA MARYLAND HEALTH CARE SYSTEM PERRY POINT CECIL If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 1 ÅM 2 ☐ F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Mary Land 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 213-62-0366 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 is marked other than "natural", or itema 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Maryland Howard Ellicott City 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 4572 Kingscup Court 21042 Funera 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Wes 2 ☐ No 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2X No White Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Staff Sargeant 12 Army 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be nent of Health and Mental John Preston Dickens, Sr. Emma O. Wood 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mandy Yu Daughter 4572 Kingscup Court; Ellicott City, MD 21042 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of F.
Important: If ite
any injury or ott 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Baltimore National 3/15/04 Baltimore, Maryland *4 □Donation 5 □Other (Specify) ²² Name and Address of Facility
Sterling Ashton Schwab Funeral Home, 21228
736 Edmondson Avenue; Baltimore, MD, 21228 21. Signature of Funeral Service Licensee Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HEPATIC FAILURE Pnysician UNKNOWN /Medical Due to (or as a consequence of): Examiner LIVER CIRRHOSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executad HEPATITIS C Due to (or as a consequence of): by Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Hnknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 4No 25. Was case referred to medical examiner? filled in by the funaral director, 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XInpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 5 Pending investigation 1XX Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Płace of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 042014 Sodh MARCH 11,2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SURINDERPAL SODHI, M.D., VA MARYLAND HEALTH CARE SYSTEM, PERRY POINT, MD., 21902

State Registrar

PHYSICIAN: DICKENS, JOHN

Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

31. Date filed (Month, Day, Year)

MAR 1 8 2004

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 08612 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) March 14, 20°0°4 5:30 P.M **Physician** Frederick Kenneth Esposite /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner Rosedale

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Franklin Square Hospital Center Baltimore Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday)
74 Yrs. **Funeral** 1€ M 2 F 214-26-6767 Sept. 23, 1929 Maryland Director Usuat Residence of Decedent 10d. tnside City Limits 10c. City, Town or Location 10a State 10b. County 1 ☐ Yes 2 ☑No Baltimore Perry Hall Md. Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 4409 Wynn Road 21236 USA Completed by Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Never Married 2 Married 1 ☐Yes 2 ☐ No If Yes, Give 1 ☐ Yes 2 No Specify: ō Saltimore, Maryland 21215-0036 Specify: White 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 1951 - 55 "neturel" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Etementary/Secondary (0-12) Supervisor Eastern Stainless 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Marie Shipley William Esposite 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4409 Wynn Road Baltimore, Maryland 21236 Grace Esposite (wife) 20b. Place of Disposition (Name of 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Crownsville Vet. 3/17/04 Crownsville, Md. * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facili Kaczorowski Funeral Home, 21. Signature of Funeral Service Licensee cuge 1201 Dundalk Ave. Baltimore, Md 21222 (cellon 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Listionly one cause on each line. Onset and Death Immediate Cause (Finat a Respiratory Failure **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner End Stage Non Small Cell Lung Cancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examiner death certificate be executed attending physician and for use as the burial-transit Chronic Obstructive Pulmonary Disease resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Pneumonia IE FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetat death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknows Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Congestive Heart Failure Be Completed Benign Prostatic Hypertrophy 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? Atrial Fibrillation, Abestosis 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitat: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 \(\tag{Nursing Home} \) 5 \(\tag{Residence} \) 6 \(\tag{Other} \) (Specify) 1 ☐ Yes 2 No Certification; To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Naturat 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signatule and titte of certifier 29c. License number 29d. Date signed (Month, Day, Year) March 14, 2004 RES 00000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Maw 00, MD 9000 Franklin Square Drive Baltimore, Maryland 21237 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 1 8 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 200 \mathfrak{j}_{\sharp} 08613 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 2:45 PM N Flair Ring March 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5505 Hopking Johns Hopkins Banview Care Cente Baltimore Byview circle 21224 MI) 7. Age (In yrs. last birthday) If Under Months Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 💢 F 213-28-0551 Director 74 August 11,1929 MD. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Itama 23a or 28a-f show the Medical Examiner must be notified at Director MD. Baltimore Dundalk 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1924 Queensway 21222 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2√☐ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry within 72 Elementary/Secondary (0-12) College (1-4or 5+) and Mental Hygiene. 11 years Housewife Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mental H Thomas Graef Ethel Mae Rishel or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is m any injury or other traum Paul Flair 1924 Queensway, Dundalk, Md. husband 21222 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State March 2004 20 4 Donation 5 Dother (Specify) Cedar Hill Baltimore, MD. 21. Signature of Funeral/Service Licensee Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 23a. Part1. Enter the disease, or complications that caused the death. Donot enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List brity one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 4 Cute ena Physician day /Medical Due to (or as a consequence ot). Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner death certificate be executed burial-transil Osteom Due to (or as a consequence of): Box 68760, Sacra Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 menths? 1 ☐ Yes 2 No 3 Ectopic pregnancy detached for Month Dav 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown ۵ been signed t should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s certificate has autopsy performed? Yes 2 No Division of Vital 1 Yes 25. Was case referred to medical examiner? director 26. Place of Death (Check only one) Hospital: Cther: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA this filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of : After 1 Certification: 28d. Describe how injury occurred 5 Pending 1 Natural Injury death. 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of tnjury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Hospitel or Descrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) the st 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5505 Hopkins Dayvier ircle, Baltimore Leve 31. Date tiled (Month, Day, Year) 32. Registrar's Signature State MAR 1 8 2004 Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 08614 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Year Physician SAAC 2:16 pm 2004 march /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner BALTIHORE AT (HOSPICE) MERCY

7. Age (In yrs. Jest birthdey) If Under 1 Year MARIS If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Months Days Hours **∭** M 2□ F 219-40-5880 Usual Residence of Decedent Director permit. Pagas 1 end 2 should be filed within 72 hours aftar daath with the Meryland Depertment of Haalth end Mantal Hygiena. Important: If Item 27 ie marked other than "naturel", or items 23s or 28s-f ehow 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or flems 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 12 Yes 2 □ No Funeral Director MARYLAND 10g/ Citizen of What Country? 10e. Street and Number THERINE 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race Race - American Indian, Black, White, etc. 11. Marital Stetus 1 ☐ Yes 2 K No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 22No Specify. BLACK Be Completed by 3 Widowed 4/S Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) CONSTRUCTION OTHGRADE WORKER ONSTRUCTION Baltimore, Maryland 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Sumame) SR. SAAC OROTH 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20b. Place of Disposition (Name of cemetery, crematory or other place) STER CATHERINE ST. INNISE other 20a. Method of Disposition Date 2 c. Location - City or Town, State 20 1 Burial 2 Cremation 3 Removal from State BUTUS CEMETERS 4 ☐ Donation 5 ☐ Other (Specify) Injury 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 21485 ULTON AVE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory rrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) prosenta Examiner Due to (or es a consequence of) Physician/Medical Examiner ettending physician and for usa es tha bunal-trensit or Attending Physician: The lew raquires that the death certificeta be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Due to (or es a consequence of) To the Hospital or Attending Physician: The lew raquires that tha des within 24 hours after death.

To the Funeral Director: After this cartificete hes been signed by tha e complately filled in by tha funeral director, page 2 should be detached it Part II. Other algnificant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 22110 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medicai Certification: To 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 Natural 5 Pending investigation Injury 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner steted. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Yeer) 3/12/2004 410854 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SEVERO DO DO DE LA COMPANIA DEL COMPANIA DE LA COMPANIA DEL COMPANIA DE LA COMPAN

DHMH 16 Rev 6/95

State Registrar Year

2004

31. Date filed (Month) Day.

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	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I		If Under 1 Year Months Days	If Under 24 Hours	Min.	Date of Birth (Month, Day,	(ear)	9. Birthp Cour	place (State or Foreign
	Director		219-50-4938	M 2⊠F 60	Yrs.			S	EP 30,	1943	Mar	yland
	land If		Usual Residence of Decedent 10a. State 10b. County	10c. City	y, Town or Lo	cation					1	Od. Inside City Limits
	Mary -1 • h	ţo	Maryland Baltimo	re		Randa	11sto	wn				1 ☐ Yes 2 🛣 No
	h the	Directo	10e. Street and Number			10f. Zip Code			10	g. Citizen of W		ntry?
	23a c		9109 Liberty R	load			133				JSA	
	er dea	Funerai	11. Maritar States	2. Was Decedent Ever in U. Armed Forces?	S. 13. \	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin In, Mexican, P	? (Specif uerto Ric	y Yes or No- an, etc.)		- Amend c, White,	ean Indian, etc.
50	be filed within 72 hours atter death with the Maryland ital Hygiene. d other then "natural", or iteme 23a or 28e-f ehow event, the Madical Examinat must be twittled at	by F	1 Mover Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1□Yes 2∏XNo	Specify:			Specify:	Whi	te
ž	2 hou		15. Decedent's Educi (Specify only highest grade	ation	16a. Deced	tent's Usual Occupa	ation	l working	1	6b. Kind of Bu	siness/In	dustry
7	thin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	DO NOT use retired	1)	working		NT /		
7	filed w Hygien Sther th		17. Father's Name (First, Middle, Last)		Nev	<u>er Work</u>		Name /F	irst, Middle, M.	N /		· · · · · ·
yland		o Be	James Charles F	lutka					Bertha			i
C .	d 2 should th and Men 7 is marks traumatic	ř	19a. Informant's Name/Relationship (Typ		19b. Mailir	ng Address (Street	and Number o	or Rural R	oute Number,	City or Town, S	State, Zip	Code)
Z	12 ha 7 is		James L. Flutka,	Sr./Brothe	r 12	26 Newf	ield]	Road	Balt:	imore,	MD	21207
G.	- F = =		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Re		lace of Dispo	sition (Name of natory or other place	ce)	Date	9 2	Oc. Location -	City or To	own, State
Ē	Peges ment of ent: If it		* 4 □Donation 5 □ Other (Specify)	Met		matory,]				Baltim		, MD
Salt	permit. Peges Department of I importent: If it any injury or of		21. Signature of Juneral Service Licenses	N		remation						5 01000
	40340		Edward A Gre 23a. Part 1. Enter the disease or complice	gorchik		99 Fred					, M	Approximate
	S.		shock, or heart failure. List only one	e cause on each line.								Interval Between Onset and Death
).	Physician /Medical		disease or condition resulting in death)	Due to (or as a conseq	uence of):	CHO GENIO	CARC	INO	MA			
	Examiner		h h		STRUCT	IVE PULM	PARMOT	0	SISEASI	E .		
	D =	ner	if any, leading to immediate cause. Enter Underlying	Due to (or as a conseq				1				
	ecute and trans	Examine	Cause (Disease or injury that initiated events c. resulting in death) Last	Due to (or as a conseq	neuce of).							
8/60,	The law requires that the death certificate be executed to has been signed by the attending physicien and oage 2 should be detached for use as the burial-transit	aiE		220 (0. 232 33234	201120 21/1							
289	ificate g phys as the	edicai	a.									
XOR	leath certifica attending ph I for use as tl	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		Ectopic pregnancy	,			23d. Date		
	death	sicia	in the past 12 months? 1 Tyes 2 No	4☐ Pregnant at time of d		Other (specify)				Mor	ith	Day Year
J.	res that the de signed by the a l be detached f	Phy	9 ☐ Unknown ` Part II. Other significant conditions conf		ulting in the u	nderhing cause an	en in Part I		23e. Did toba	acco use contr	ibute to t	he cause of death?
Š	ires the signer	i by	DEMENTIA	thought to death but not res	alling in the a	noenying cause giv	errir act.				3 🔲 Prot	A.a.
000	w require been signatured should?	Completed							24a. Was an	24b. V	Vere auto	ppsy findings available
ě	he lav e has age 2	dmc							autopsy perform	ed? d	rior to co eath? Yes	mpletion of cause of
ta	an: T tificat tor, pa	Be Co	25. Was case referred to medical				26. Place of	f Death (Check on one		_ 163	2,4,110
<u> </u>	nysicl nis cer i direc	To B	examiner? 1 ☐ Yes 2 No	ospital: 1 npatient 2	ER/Outpatier	nt 3 DOA Oth	er: 4 🗆 Nursi	ing Home	5 🗆 Resider	nce 6 🗆 Othe	er (Speci	(y)
0	ing Pl		27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	Wor	k?		d. Describe hov	w injury occurre	be	
20	death death stor: /	icati	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At h	ome farm st		Yes 2 □ No		f. Location (Str	eet and Numbe	er or Run	al Route Number,
Division of Vital Records,	after Direction by	Certification:	4 Homicide determined	building, etc. (Specif	(y)	ident, ractory, emice			City or Town,	State)		
_	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate haccompletely filled in by the funeral director, page			ician: To the best of my kno								
	he Ho in 24 he Fu pletel	Medical	(Check only 2 Medical Examin	er: On the basis of examina and manner stated.	ation and/or in			occurred				
	To I	Σ	29b. Signature and title of certifies	nesta m.o		29c. Licens	4141	n		d. Date signed	11	Day, Year)
)			100		. 000					ion a 1	0 ',	and.
	2		30. Name and address of person who co	mpleted cause of death (Iter			10 EK 1			2113	2	
	St	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signa	-	-	I LIN	12	ALIBET	711 3	-	
	Regist		MAR 1 8 2004	Maria H	Book	The same						

08616 State of Maryland / Department of Health and Mental Hygien 1 1 - For State Registrar Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) MARCH **Physician** 2004 230 PM FEREBEE RAYNELL /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) **Examiner** EDGEWOOD HARFOR D CT mw wood 4 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sax **Funeral** 1 □ M 20 F man Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State 10b. County worle r then "naturel", or items 23s or 28s-f ehov tre Medical Examinar must be notified at 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 160 wood neadow Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Giv 14. Race - American Indian, 11. Marital Status Black, White, etc. ges 1 and 2 should be filed within 72 hours after to Health and Mental Hygiene.
If item 27 is marked other then "naturel", or ites 1 Never Married 2 Married 3 Widowed 4 Divorced 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify ac þ Year or Dates Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working

#fe. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry nuls of I Hygiene. Elementary/Secondary (0-12) College (1-4er 5-0016 Base NAVAL 18. Mother's Name (First, Middle, Maiden Sumame) er's Name (First, Middle, Last, section munde min 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) - mother 20 Gittingon 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete Method of Disposition Pages 1 Surial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If ony injury or 0120 04 arnel Cemi 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility recial Lvallac Janen m Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due (o (or as a consequence of) **Examiner** priore Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit be executed and Due to (or as a consequence of) ate has been signed by the attending physicien page 2 should be detached for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 □Unknown 1 Yes 2 🗆 No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a. Was an autopsy performe certificate has 2 No 1 ☐ Yes na director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Hospital: 1 Yes 2 No 3 DOA 4 ☐ Nursing Home 5 → Residence 6 ☐ Other (Specify) 2 1 ☐ Inpatient 2 ☐ ER/Outpatient this 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Certification: After t Hospital or Attending Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 9 MD, D0014206 DME eted cause of death (Item 23a) (Type, Print) HOLABIRD AVE UKNA MD DME 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

18

State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** MIRACLE TANAE GREEN 06:10 AM MARCH 10 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner UNIVERSITY OF MARYLAND MEDICAL CENTER BALTIMORE N/A Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 6. Sex **Funeral** Days Min 1 M 2 AF 9,2003 -67-8009 MAR Director LAND Usual Residence of Decedent deeth with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or items 23a or 28a-f show treumatic event, the Mudical Examiner hust be notified at 1 X Yes 2 No Funeral Director MARKLAND 10e. Street and Number g. Citizen of What Country? 2121 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours efter 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: þ 3 Widowed 4 Divorced "natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry if Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Peges 1 end 2 should be lited 17. Father's Name (First, Middle, Last) (UNKNEWN) 18. Mother's Name (First, Middle, Maiden Surname) Be YONAE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ANTOINETTE other t 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition ō 12 Burial 2 Cremation 3 Removal from State ō Department important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Add ss of Facility 21. Signature of Funeral Service Ligensee FULTON AVE Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** CHRONIC LUNG DISEASE disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** PULMONARY HYPERTEN SION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Completed by Physician/Medical Examiner Due to (or as a consequence of): To the Hospitel or Attending Physician: The law requires that the death certificate be executed RENAL INSUFFICIENCE for use as the burial-tran that initiated events attending physician and resulting in death) Last Due to (or as a consequence of): Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Cher (specify) 1 ☐ Yes 2 No be detached o 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed 1 ☐ Yes 2 ☒ No 2⊠ No Division of Vital funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Medical Certification: To Be Hospital: 1 ⊠Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☒ No this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 🛭 Natural within 24 hours after death.

To the Funerel Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated 29b. Signatur and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) a hashin 17321 MARCH 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PEDIATRICS BALTIMORE NADEEM HASHMI, MD DEPT. OF UMMC 31. Date filed (Month, Day, Year) MAR 1 8 2004 32. Registrar's Signature Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) March 15^{pay} 2004 **Physician** Bernice Grunwell 1:20P M /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Ellicott City Howard Morningside If Under 1 Year If Under 24 Hrs. | Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2X F 222-12-2637 79 Director Pennsylvania Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hygiene.
ans: If item 27 is marked other than "naturat", or items 23a or 28a-f show ans: If item 27 is marked other than "naturat", or items 24a or 28a-f show ury or other transatic event, Ita Medical Examinat mat be notified at ury or other transatic event, Ita Medical Examinat mat be notified at 1 ☐ Yes 22 ☐ No Director Maryland Howard Ellicott City 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5330 Dorsey Hall Drive Apt#201 21042 U.S.A. by Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 21X No 1 Never Married 2 Married 1 ☐ Yes 2XXVo Baltimore, Maryland 21215-0036 Specify: Il Yes, Give Year or Dates: 3 ₩ Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Joseph Balentine Estelle Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harry Grunwell (Son) 11159 Willow Green Way Marriottsville, MD 21104 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any injury or ot once. 1 ☑ Buriai 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Lawn Croft Cemetery 3-18-2004 | Linwood, PA 21. Signature of Funeral Service License 22. Name and Address of Facilit Witzke Funeral Home of Catonsville, Ir 1630 Edmondson Avenue Catonsville, MD Inc. D 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Oeath Immediate Cause (Final ronar Pnysician resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consumence of: Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death 1 Live birth in the past 12 mont Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 Yes 2 No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 94a. Wasan s certificate has threater, page 2 s autopsy performed 1 Yes 2₽No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 1 ☐ Yes 2 ☐ 10 4 Tursing Home 5 Residence 6 Other (Specify) Certification: To funeral dir 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred After 1 ⊟Natural 5 Pending 1 ☐ Yes 2 ☐ No death. within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital t 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the ! 29b. Signature and title of contifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type 31. Date filed (Month, Day, Year) Registrar's Signature State 18 2004 Registra

			1 - For State Registrar	State of M	aryland / Dep. <i>Ce</i>	artment of Healt <i>rtificate of Dea</i>	th and Mental Hyg ath	giene 2004 Reg. No.	08620
П	Dhuaiai		Decedent's Name (First, Middle,	Last)			2. Date of De		3. Time of Death
	Physici /Medic		James Gardner			4b. City, Town, or Local	March	15 2004 4c. County of Death	8:45 PM
	Examin	er		Sex 7. A	River NH.	Edge Wo	oder 24 Hrs. 8. Date of Birt	Baltimore	place (State or Foreign
н	Funeral Director		239-12-4612	1□ ∦ 2□F	90 ^{Yrs.}	Months Days Hou		у, ^{Үөаг)} Соці 1 , 1913 NC	ntry)
	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation			10d. Inside City Limits
	Maryl	tor	MD Balti	TOTA	Edgewood				1 ☐ Yes 2 ☐ No
	or 28e	Director	10e. Street and Number		паденоса	10f. Zip Code		10g. Citizen of What Cour	ntry?
9	within 72 hours after death with the Maryland liene. r then "natural", or items 23e or 28e-f show the Medical Exercitiva count be mufflied at	Funerai	144 Washington 11. Marital Status 1 Never Married 2 Marrie	12. Was Decedent Armed Forces 1 Yes 2 If Yes, Give	P No		c Origin? (Specify Yes or No- xican, Puerto Rican, etc.)	United Stat 14. Race - Americ Black, White, Specify:	:es :an Indian, etc.
9	hours tural',	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		dent's Usual Occupation		16b. King of Business/In	dustry
Maryland 21215-0036	within 72 ene. then "nei	Completed	(Specify only highest Elementary/Secondary (0-12)		(Give	kind of work done during DO NOT use retired)	most of working	Factory	220,
21	e filed within Il Hygiene. other then vent, tre Me	Com	6		Labo	rer			
and	ntal H ad oth) Be	17. Father's Name (First, Middle, L.	ast)		18. N	Nother's Name (First, Middle,	Maiden Sumame)	
JY.	should be nd Mental rmarked (umetic ev	၉	Unknown 19a. Informant's Name/Relationshi	p (Type, Print)	19b. Maili		known umber or Rural Route Numbe	er, City or Town, State, Zip	Code)
	Pages 1 and 2 should be filed nent of Health and Mental Hyg int: If Item 27 is marked othe iry or other treumetic event,		Bernice Cunning 20a. Method of Disposition 1 Burial 2 Cremation	— B □Removal from State		North Lake osition (Name of matory or other place)	wood Aye., Ba	2°c. Localion City or To	21 213 wn, State
Baltimore,	permit. Pages Department of Importent: If i any injury or o		*4 □Donation 5 □ Other (Sp. 21. Signature of Funeral Service L		Mount C	armel Cem 2. Name and d ress of F	Apr 20 2004	Baltimore,	MD
<u> </u>	9 G E 5 G		23a. Part1. Enter the disease, or o	2 Millian	8	Calvin L. Wi	lliams Funera	l Home, P.A	MD
	Physician /Medical Examiner	iner	shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a. Due to (or as	ine. CC Ayy s a consequence of): s a consequence of):	hytomic	Vosculær	·	Onset and Death LO minute
68760,	ficate be executed g physician and as the burial-transit	edical Exami	Cause (Disease or injury that initiated events resulting in death) Last	c	s a consequence of):				
O. Box	The law requires that the death certifule has been signed by the attending tage 2 should be detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)		23d. Date of delive Month	ery Day Year
<u>α</u>	quires that n signed b ıld be deta		Part II. Other significant condition	Demen		inderlying cause given in F		obacco use contribute to the Yes 2 □ No 3 □ Prob	
Division of Vital Records,		Completed by	Prostate	ccence	7.			an 24b. Were auto prior to condeath? 1 Yes	psy findings available mpletion of cause of
Vita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Place of Death (Check only o		
of	Phys this ral du	. To	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 □ Inpat	ury 28b. Time o	of 28c. Injury at	Nursing Home 5 Resid	dence 6 ∐Other (Specifi now injury occurred	/)
ion	ttending Phideath. ctor: After thi	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investiga	ition	ay Year) Injury	Work? M 1 ☐ Yes	2 □No		
Divis	ei or Attending s after death. il Director: After id in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could no determine	200. Flace Of II	ijury - At home, farm, st tc. <i>(Specify)</i>	reet, factory, office	28f. Location (5 City or Tow	Street and Number or Rura vn. State)	I Route Number,
	To the Hospitei or Attent within 24 hours after death To the Funerel Director: completely filled in by the	edicai C	29a. Certifier 1 Certifying (Check only one)	Physician: To the best xaminer: On the basis of and manner s	of examination and/or in	th occurred at the time, dance to the time, dance t	te and place, and due to the o , death occurred at the time, o	cause(s) and manner as s date and place, and due to	ated. the cause(s)
)	To the within 2 To the Complet	Me	29b. Signature and title of certifier	w-c	Smana	29c. License num		29d. Date signed (Month, $3 - 15$	
,	3		30. Name and address of person w	no completed cause of	death (Item 23a) (Type,	Print) GYAN	0653 1.C. St.	IRANA	2075/
	Sta Registi		31. Date filed (Month, Day, Year)		trar's Signature	books			

			1 - For State of Ma	aryland / Depa	artment of F			200	08621
	Physic		Decedent's Name (First, Middle, Last) CECELIA RITA GRIFFIN				2. Date of Death Month	Day Y	3. Time of Death
	/Medi Examir		4a. Facility Name (If not institution, give street and number)	OSPITAL	BALTIA			4c. County of N/.	Death
	Funeral Director		5. Social Security Number 220-48-8714 Usual Residence of Decedent	e (In yrs. last birthday) 91 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y		. Birthplace (State or Foreign Country) MARYLAND
	ith the Maryland or 28e-f show	tor	10a. State 10b. County MD N/A	10c. City, Town or Lo					10d. Inside City Limits XXYes 2 ☐ No
	death with the Maryland ms 23e or 28e-f show ritust be rediffed at	Funeral Director	10e. Street and Number 1808 N. PULASKI ST.		10f. Zip Code 21217		10g	. Citizen of Wha	at Country?
	5-0036 72 hours after deatt naturel', or Items 2	by Funera	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 1 Yes, Give 1 Widowed 4 Divorced 12. Was Decedent Armed Forces? 1 Yes, Cive 18 Yes, Give 19 Year or Dates:	No	Was Decedent of H If Yes, specify Cuba 1 Yes 2 No	tispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		American Indian, White, etc. BLACK
CELIA	21215-0036 d within 72 hours aff gione. r then "naturel", or	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5	(Give	dent's Usual Occup kind of work done DO NOT use retired	nation during most of work d)	ing 16	b. Kind of Busin	ness/Industry
Cec	and 21 d be filed v antal Hygie ted other t	Be		HO	USEKEEPER		e (First, Middle, Ma	DOMES (den Sumame)	STIC
2	Maryland Id 2 should be file Ith and Mental Hy Ith smarked oth Treumatic eveni	2	19a. Informant's Name/Relationship (Type, Print) JOSEPH M. GRIFFIN(SON)		-	and Number or Rur	al Route Number, C		
	Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. In proprient: If item 27 is marked other then "naturel", or items 23e or 28e-18 show any pictor other treumatic event, ite Medical Exprimer must be notified at once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from State 1 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Disponentery, creed NEW CATH	esition (Name of matory or other place EDRAL CEM R Name and Addre	ETERY_3-2	Date 20 23-2004 BA ILLIPS FUN	c. Location - Cit ALTIMORI NERAL HO	LAND 21217 y or Town, State E. MARYLAND DME, P.A. ARYLAND 21217
•	icate be executed was physician and physician and surial-transit united in the burial-transit united in	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Myocaro		Carction ny Vasu	plan Di	seaso	Interval Between Onset and Death
	Division of Vital Records, P.O. Box 68 for Attending Physicien: The law requires that the death certifica after death. Director: After this certificate has been signed by the attending ph tin by the funeral director, page 2 should be detached for use as it.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3]Ectopic pregnancy] Other (specify)	1		23d. Date of Month	f delivery Day Year
	cords, P. wrequires that t been signed by should be detac	þ	Part II. Other significant conditions contributing to death be Chronic obstructive pur	elmonan	diseas	en in Part I.	1 ☐ Yes	2□No 3[te to the cause of death? Probably 4 20nknown
	Vital Rec vicion: The law certificate has t rector, page 2 s	Completed	with gastrointestinal &	SIS, Rece bleeding	ent co.	litis		prior	
	on of Vital Reding Physicien: The Inding Physicien: The Indinate the Atter this certificate he funeral director, page	To Be	25. Was case referred to medical examiner? 1 ★ Yes 2 No 1 ★ Nonner of Death (Month, Da)		- N	er: 4 🗆 Nursing Ho	h (Check only one) me 5 Residence 28d. Describe how		Specify)
	Division I or Attending after death. Director: After	Certification:	2 Accident investigation	ury - At home, farm, str	M 1	k? Yes 2 □ No	28f. Location (Stree City or Town, S		or Rural Route Number,
	Divisit To the Hospitel or Attence within 24 hours atter death To the Funerel Director: completely filled in by the	Medical C	29a. Certifier (Check only one) Check only one) Check only one) Check only one) Check only one one one of the basis of and manner start.	examination and/or in	n occurred at the tin vestigation, in my o	ne, date and place, pinion, deeth occur	and due to the caus red at the time, date	se(s) and manne and place, and	er as stated. due to the cause(s)
•	To the within To the company of the the company of the the company of the the company of the	×	29b. Signature and title of certifier Mona I Samenna	Patholog	29c. Licenson				fonth, Day, Year) 1200 4
	3		30. Name and address of person who completed cause of d 401ra Plarsen, M		tan Hosp	nital 50	ool Lach	Raven t	12004 BIVd Baltomo
	Sta Regist		31. Date filed (Month, Day, Year) 32. Registra MAR 1 8 2004	ar's Signature	Sonster				

Coldberg, Lean Harold Baltimore, Maryland 21215-0036

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1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Pi / Ex
Division of Vital Records, P.O. Box 68760,	a Hospitel or Attanding Physician: The faw requires that the death certificate be executed

-				Please	Type or Prin								e	2
		_	For State Registrar			aryla		rtment of l	Health and N Death	Mental Hy	/giene		4 086	22
Phys	sicia	n	Decedent's Nam	ne (First, Middle, Las	st)			GOLDBERG		2. Date of D Month	Day			
	edica mine		4a. Facility Name (LEON If not institution, give	street and number)				or Location of Death	March		County of E		o PM
LAU			Sinai	Hospita		11+	more	Baltin	(,)	44		o o o o o	N/A	
Fune Direct			5. Social Security N 220-22-		ex 7. Ag		s. last birthday) 1 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of B	of Birth th, Day, Year) 19,1922			or Foreign
	.01		Usual Residence o		^					INOV.1	9,192			MD
larylar show		_	10a. State	10b. County	TMODE	10c. 0	City, Town or Lo						10d. Inside Ci	
the N 28a-f		rect	MD 10e. Street and Nu		IMORE		KEISI	ERSTOWN			10a Citi:	zen of Whai	1 Tes	- X NO
th with 23a o		runeral Director	92 EAST	CHESTNUT	HILL LANE	=			21136				U.S.A.	
er dea		uner	11. Marital Status		12. Was Decedent I Armed Forces?		U.S. 13. V	Vas Decedent of F Yes, specify Cub	fispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or N Rican, etc.)	0-		American Indian, Vhite, etc.	
If 5, Wild yild IN Z IZ IS 10000 8.1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene. If an I is marked of their than "netural", or Items 23a or 28a-1 show other traumatic event. It is Modical Export by the published at		2	1 U Never Marr		1 Yes 2 XN If Yes, Give Year or Dates:	10		□Yes 2X No				Specify:	WH1	ITE
in 72 t		aleic	(Spec	15. Decedent's Ed cify only highest gra	de completed)		(Give I	ent's Usual Occup kind of work done O NOT use retire	during most of work	ing	16b. Kir	nd of Busine	ess/Industry	
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be file trat Hy d oth		מ		(First, Middle, Last)			001.00	ED 0	18. Mother's Name	e (First, Middle	, Maiden	,		
an yianing K. I.K. 2 should be filed withi and Mental Hygiene. is marked other than sumatic event, II e.M.	F	2	NATHAN	ame/Relationship (7	'una Print)		GOL DB		LENA	-/5	0"		SCHNEIDER	₹
and 2 s and 2 s ealth ar n 27 is	H			GOLDBERG					and Number or Run					21136
permit. Pages 1 and 2 Department of Health a Important: If itam 27 is any injury or other tra		-	20a. Method of Dis		Removal from State	20b.	Place of Dispos	ition (Name of atory or other place	(ec	Date	20c. Loc	cation - City	or Town, State	
it. Pac			` 4 ☐ Donation	5 Other (Specify)	MI			ISRAEL 3				MORE, MD	1
permit. Departri	once.		21. Signature	M MILL T	S 90				ss of Facility SOL ERSTOWN R					10
	1		23a. Part1. Enter t	he disease, or come	lications that caused one cause on each lin	the dea						VILLE	Approximate	
Pnysicia	_		immediate Cause disease or condition	(Final	Acute		100010	al infa	rition				Onset and D	eath
/Medic Examine	_		resulting in death)		Due to (or as a	a conse	quence of):						1 - 1(04	17.2
dr.		į į	Sequentially list co if any, leading to in cause. Enter Unde Cause (Disease or	nditions, imediate	bSCN(M)	CONSU	quence of).	myopath	'7					
be executed ician and burial-transit			Cause (Disease or that initiated events resulting in death) I	5	c									
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leath certificate be attending physic	100	2			d									_
ath cer tendin or use	M/dc		IF FEMALE: 23b. Was deceden in the past 12	L pregnant	23c. If yes, outcome o			Ectopic pregnancy			23	3d. Date of		
Attanding Physician: The law requires that the death certificate releases. After this certificate has been signed by the attending phys by the funeral director, page 2 should be detached for use as the	Dhydiola/Mode	2	1 ☐ Yes 2 ☐ 9 ☐ Unknown	□No	4□Pregnant at t 9□ Unknown	time of		Other (specify)				Month	Day Y	ear
res that I	hy Dh			icant conditions co	ntributing to death bu	t not re	sulting in the und	ferlying cause give	en in Part I.	23e. Did t	obacco us	e contribute	to the cause of de	eath?
w require been sig should b	100		Atrial	Filacilletio	Λ					10	Yes 2. ▼	No 3□	Probably 4 U	nknown
e 2 sh	Completed	-								24a. Was		24b. Were	autopsy findings a	vailable use of
ician: The certilicate he	200		05. 14/22 2222 22622							1 ☐ Yes		death	?	
ysician: is certific director,	0	3	25. Was case reference examiner? 1 ☐ Yes 2 ☑		Hospital: 1 Inpatier	nt 2	ER/Outpatient	3 □ DOA Othe	26. Place of Death er: 4 ☐ Nursing Hor		111:		200	
ng Phys fter this ineral di	F .		27. Manner of Death	h 5 ☐ Pending	28a. Date of Injury (Month, Day		28b. Time of Injury	28c. Injury Work	at 2	28d. Describe			о в спу)	
ttandi death. :tor: A	40		2 Accident 3 Suicide	investigation 6 Could not be					Yes 2□No					
after after I Direct	Cartification.		4 Homicide	determined	28e. Place of Inju- building, etc.	ry - At h . <i>(Speci</i>	ome, tarm, stree fy)	et, factory, office	2	28f. Location (S City or Tox	Street and vn, State)	Number or	Rural Route Numb	er,
To tha Hospitel or Attanding I within 24 hours after death. To tha Funaral Director: After completely filled in by the funer	Olevipa		29a. Certifier (Check only one)	1 Certifying Phy 2 ☐ Medicel Exemi	sicien: To the best of	examina	owledge, death of ation and/or inve	occurred at the tim stigation, in my op	ne, date and place, a pinion, death occurre	and due to the o	cause(s) a	nd manner	as stated. ue to the cause(s)	
o tha	May		29b. Signature and		and manner stat			29c. License					nth, Day, Year)	
F>F0			1	(ca)	er			RES	-000					
1	7	,3	30. Name and addre	ess of person who co	ompleted cause of de			1 . ~	7 ,1		1000		244	
* (State		31 Date filed /Mont	th, Day, Year)		Si Ac		itel of	Baltin	nose				
Regi			MAR	1 8 2004	A CONTRACT	A STATE OF THE PARTY OF THE PAR	ature							

			For State Registrar		Sta	ate of	Maryla	nd / Dep <i>Ce</i>	artmen rtificat	t of H e of L	ealth a	and M		Heg. No.	2004	08623
	Physici	an	1. Decedent's Name	(First, Middle, I	.ast)								2. Date of De Month	Day	Year	3. Time of Death
	/Medi		Helen			inks						10	March			1:30 A M
V	Examir	ner	4a. Facility Name (If			and num	ber)				Location			4c. C	County of Death	
	Euroval		Genesis No. 5. Social Security Nu.		Home	7	7. Age (In yrs	. last birthday,	If Under	1 Year	If Under	24 Hrs.	8. Date of Bir	rth	nne Aru 9. Bjrth	place (State or Foreign
	Funeral Director		216-66-43		1 ☐ M 2		84	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da July	29, 19	19 Mar	yland
	P .		Usual Residence of	Decedent 10b. County			100.0	city, Town or L	nantine.							10d. Inside City Limits
	laryla •hov	5	Maryland	Baltim	re		1 _	Baltimo								1 ☐ Yes 2 ☐ No
	the N 28a-f	ect	10e. Street and Num					ZILIIO	10f. Zip	Code		-		10g. Citize	en of What Cou	77
	3 or		3204 Hill	top Ave	nue					212	27				USA	
	deeth	Funeral Director	11. Marital Status	<u> </u>	12. W	as Deced	dent Ever in I	U.S. 13.	Was Dece			gin? (Spe	city Yes or No Rican, etc.))- 1 ₀	4. Race - Amer Black, White	
9	or Ite	E.	1 Never Marrie		1 1 (☐ Yes 2 Yes, Give	2 [XNo		1 Yes		Specify:		110011, 010.,		Specify: Wh	
Š	il Z I 3-0030 within 72 hours after deeth with the Maryland ene. then "naturel", or Itema 23e or 28e-f ehow he Madical Examinar must be notified at	d by	3 Widowed		Ye	ear or Da	tes:	163 Docs	dent's Usua		ation				d of Business/li	
Į,	0 72 In 72	olete	(Speci	15. Decedent's fy only highest	grade com	pleted)	20.53	(Give	kind of wo	rk done d	lurina mos	t of workin	ng	TOD. KIN	d of business/ii	loustry
3	d with	Completed	Elementary/Secor 5	ndary (0-12)	Co	otlege (1-	40r 5+)	Home	maker						Own Ho	ne
•	nd file	BeC	17. Father's Name ((First, Middle		Sumame)	
	Via Suld b Ment Ment Ment arked	10	Charles A										V. Emme			
	Mar 12 sh h and 7 is m raum		19a. Informant's Na H. Bruce I			rint)									Town, State, Zi	
•	other trans		20a. Method of Disp	<u>.</u>	5011		20b.	Place of Disp	osition (Nar	ne of			ate		ation - City or T	land 21146 own, State
	BAITIMORE, MARYIANG ZIZIS-UU30 permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Itema 23e or 28a-f ehow any injury or other traumatic event, the Madical Examinat har notified at once.		1 SuBuriai 2 Substitution	Cremation 3		al from S	LO	cemetery, cre udon Pa				3/15	/04		•	Maryland
3	altif nit. P partme orten injur		21. Signature of Fur								_				al Home	
	Depariment of the police of th		MES	Unor	S	Bin	5	4	107 W	ilke	ne Av	enue,	. Ealti	more,	Maryla	and 21229
	****		23a. Part1. Enter the shock, or hear	e disease, or co	ly one cau	ISA OD AA	ch line	20								Approximate Interval Between
	Physician		Immediate Cause (I	Finat 1	_ a	MA	e tasta	alic	Bro	eas	t c	ar	cino	Ma		Onset and Death
	/Medical Examiner		resulting in death)	-		Due to (c	or as a conse	equence of):	t.	· C	avel	len W	celala	Di	scre	
	*	70	Sequentially list con	nditions,			or as a conse		mu	ي در	4	0000		1 /- /		
	uted nsit	Examiner	Sequentially list con if any, teading to im- cause. Enter Under Cause (Disease or i	rtying Injury				.,	•							
,	/ bU, le be executed ysician and e burial-transit	Еха	that initiated events resulting in death) L	ast	С	Due to (a	or as a conse	quence of):								
	B / bU, sate be executed hysician and the burial-transit	cal			d											
	c observition		IF FEMALE:													
(OIVISION OF VITAL RECORDS, P.O. BOX of or attending Physician: The law requires that the death certific after death. Director: After this certificate has been signed by the attending princy the funeral director, page 2 should be detached for use as in by the funeral director.	Physician/Med	23b. Was decedent in the past 12 i		1(Live bir	ome of pregr th 2 Fet	tal death 3	⊒Ectopic pi					23	Bd. Date of delive Month	ery Day Year
	the a	ysic	1 ☐ Yes 2 ☐ 9 ☐ Unknown			□Pregna □ Unknov	int at time of wn	death 5[Other (sp	овсту)						•
•	Attending Physician: The law requires that the death. Geath. sctor: After this certificate has been signed by the tuneral director, page 2 should be detached.	/Ph	Part II. Other signifi	cant conditions	s contribut	ing to dea	ath but not re	sulting in the u	ınderlying d	ause give	n in Part I		23e. Did t	obacco use	e contribute to t	he cause of death?
	tuires n sign	d by											1 🗆 '	Yes 2 🗆	No 3□Pro	bably 4 nknown
	aw requir	Completed											24a. Was		24b. Were aut	opsy findings available
1	He The lav	mo											autor perfo	ormed?	prior to co death? 1 🖂 Yes	ompletion of cause of
	r Vital Ko ysician: The is certificate ha	Be C	25. Was case referr examiner?	red to medical							26. Place	of Death	(Check only o			7
	OT V Physic this ce	၉	1 □ Yes 2 2 1		Hospita	1 🗀 In		☐ ER/Outpatie			4				Other (Speci	fy)
	ing P	lon:	27. Manner of Death 1 Z Natural	5 Pending		a. Date of (Month	f Injury n, Day Year)	28b. Time o		8c. Injury Work			8d. Describe I	how injury	occurred	
₹:	ISIC trend death ctor: , the	icat	2 Accident 3 Suicide	investigat	be 39.	e. Place o	of Injury - At I	home, farm, st	M reet factor		/es 2□		8f Location /	Street and	Number or Bur	al Route Number,
` ;	after Direction	Certification:	4 Homicide	determine	ed	buildin	g, etc. (Spec	ufy)	ioot, ractor	, omoo			City or To		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	ar riodio ridinado,
	To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral		29a. Certifier	1 Certifying	Physician	: To the t	best of my kr	nowledge, deat	h accurred	at the tim	e, date an	d place, a	nd due to the	cause(s) a	nd manner as s	stated.
	he Ho in 24 I he Fu pletel	Medical	one)	2 Medical Ex	aı	nd manne	er stated.									
	To t com	Σ	29b. Signature and	title of certifier	ລ.				290	. License	number			29d. Date	signed (Month,	Day, Year)
	'n		,	4 U	lan					03	004	7 (-	Ma	web 11	2004
	J		On the and address	ess of person wh	o complet	led partse	of death (the	om 23a) (Type	Print)	ream	An	nor	Ba	hom	we Ma	2004 2004 My land 2/3
	St	ate	31. Date filed (Mont	h, Day, Year)	01,00	32 Re	gistrar's Sign	nature	1 00V	7001	7100		7 - 1	, , , , ,	ruc	1
	Domint		1.3.1	ND 182	nn4	AY	5-88-5 d	8.5° MAG	To the second							

Blake C. Harris Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend & Unpend Item (2002) Amend & Unpend Item (04 - 1751AKG 1 - State AMEND ITEM #18 PER FH G829 3/18/04 Diertificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** March 9 2:41 PM Blake Karrington Harris 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Columbia Howard Howard County General Hospital If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days 3-0 1 🖾 M 2 🗆 F 212-69-3389 Dec 10, 2003 Maryland Director Usuet Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location e filed within 72 hours after death with the Marylan II Hygiene.
other than "natural", or Items 23a or 28a-f show vent, the Mcdical Examinar must be notified at 1 Yes 2 No Columbia MD Howard Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 5850 Stephens Forest Road #1 21045 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes ≥ 2 ☑ No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) n/a 18. Mother's Name (First, Middle, Maiden Sumame)
JULTANNE permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any injury or other traumatic svent, once. 17. Father's Name (First, Middle, Last) Be Marvin Leroy Harris, Jr. Julicanne Virginia Coon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) /mother 5850 Stephens Forest Rd. #1, Columbia, MD 21045 Julieanne V. Coon 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crestlawn Mem. Grdns Mar 15,2004 Marriottsville, MD 21. Signature of Funeral Service I centee 22. Name and Address of Facility Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Maryland 20707-4389 M00773 HW H 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Pnysician Preutonia disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disage or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed the burial-transit and Due to (or as a consequence of) P.O. Box 68760. ed by the attending physician detached for use as the buria Physician/Medical death certificate IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant for 3 Ectopic pregnancy Day in the past 12 months? 4☐ Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown been signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. þ should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2 □ No 24a. Was an page 2 autopsy performed? certificate 2 🗆 No Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Inpatient 2 1 XYes 2 □ No 2XXXPOutpatient 3 □ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident or Attend after death Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide To the Hospital within 24 hours at To the Funerel D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Dav. Year) 29b. Signature and title of certifier Ni Mid O.C.M.E. March 10, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LING LI 111 Penn Street, Baltimore, Maryland 21201 32. Registrar's Signature 31. Date filed (Month, Oay, Year) State

DHMH 17 Rev 1/2001

Registrar

MAR 1 8 2004

ORIGINAL

	Dhus		1 - For Amend Item 4 State Registrer 1. Decedent's Name (First, Middle, La	st)	<u> </u>	Oortmou	10 01		2. Date of Dea Month	ath Day	Year	3. Time of Death	
	Physici /Medi		Mary Ann Hanse			1			March 1	2, 200		9:10 AM	м
	Examir	ner	4a. Facility Name (If not institution, giv Homewood at Wil					r Location of Deat msport	n	Was	nty of Deatl	on	
	Funeral	A 1 1/2	5. Social Security Number 6. S	Sex 7. Age	(In yrs. last bir	thday) If Und	der 1 Year	If Under 24 Hrs		h v Vear)	9. Birti	nplace (State or Foreig	gn
	Director		213-44-7204	□M 2X)F	93	Yrs. Month	s Days	Hours Min.	Sept 17	, 1910)	untry) unk	_
	land		Usual Residence of Decedent 10a. State 10b. County	_	10c. City, Tow							10d. Inside City Limit	ts
$\mathbf{\Sigma}$	ith the Marylar or 28e-f show	tor	MD Frederi Washingt	ek on	Will	iamspor	t					1 ☐ Yes 2入☐ N	10
910/AM	or 28	Funeral Director	10e. Street and Number			10f. 2	Zip Code			10g. Citizen	of What Co	untry?	
~	ier death w Items 23a	rai	16505 Virginia A	venue k12. Was Decedent E	ver in II S	13 Was Dec		21795	Specify Yes or No.		USA Bace - Ame	rican Indian,	
	fler de	Fune	11. Marital Status Un	Armed Forces? 1 ☐ Yes 2 X N				lispanic Origin? (S an, Mexican, Puer	to Rican, etc.)		Black, White		
21215-0036	72 hours after death with the Maryland "natural", or Items 23a or 28e-f show	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 🗆 Yes	2 X No	Specify:		Spe	ecity:	white	
15-6		Completed	15. Decedent's E (Specify only highest gra	ade completed)		Give kind of y life. DO NOT	sual Occup work done use retire	pation during most of wo d)	rking	16b. Kind o	f Business/	Industry	
212	within jiene. r than "	mo d	Elementary/Secondary (0-12) unk	College (1-4or 5- unk	+)	homema				70	vn hon	ne	
	be filed ital Hyg id othe event,	BeC	17. Father's Name (First, Middle, Last					18. Mother's Na	me (First, Middle,	Maiden Sun	name)		
	should b ind Ments marked umatics	2	John Augustus F	laherty				l	Caroline				
DA OUT	12 sh h and 7 is m traum		19a. Informant's Name/Relationship (Ronald Hansen/so	* '	19b	3	,	and Number or Re				(ip Code) 21740	
	1 and Health tem 27		20a. Method of Disposition		20b. Place o	Disposition (A	lame of		Date	20c. Location			-
3	Pages lent of nt: If if		1 ☐ Burial 2 ☐ Cremation 3 ☐ 14 ☑ Donation 5 ☐ Other (Special		Cemete	ry, crematory o	ir otner plai	CO)					
Balti	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If tiem 27 is marked other than any injury or other fraumatic avent, In a Maones.		21. sign ture of Funer Spruce Lice	Wade Dice	EXECT .	State balti	and Addre Anat more,	omy Boar MD 212		Balti	more	Street	
			23a. Part1. Enter the disease, or com shook, or heart failure. List only	plications that caused one cause on each lin	the death. Do				c or respiratory ar	rest,		Approximate Interval Between	_
	Physician		Immediate Cause (Final disease or condition	, meta	Acet	or can	cenor	a un	lenou	ACIY	new	Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or as a	consequence	of):		7		1			
	×	er	if any, leading to immediate cause. Enter Underlying	b. Due to (or as a	consequence	of):							
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760.	ie be executed /sician and e burial-transit		resulting in death) Last	Due to (or as a	consequence	of):					- 1		
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Rox 6	law requires that the death certifica as been signed by the attending phosphould be detached for use as it.	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		_				23d.	Date of deli	ivery	
	v requires that the death cer been signed by the attendir should be detached for use	iciai	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth : 4 ☐ Pregnant at 9 ☐ Unknown		3 □Ectopic 5 □ Other		y 			Month	Day Year	
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<u></u>	an: T ifficate or. pa	a	25. Was case referred to medical					26. Place of De	1 ☐ Yes ath (Check only o		1 🗆 Yes	26€(No	
>>	Physician: this certific ral director.	To B	examiner? 1 □ Yes ☑ No	Hospital: 1 Inpatie	nt 2 ER/O	utpatient 3	DOA Ott	200	Home 5 Resid		Other (Spec	cify)	
ر ا	ng Ph fter th	ino	27. Manner of Death	28a. Date of Injur (Month, Day	y 28b. 'Year)	Time of Injury	28c. Inju	rk?	28d. Describe h	ow injury oc	curred		
9	ttendi death. tor: A the fu	icati	2 Accident investigation 3 Suicide 6 Could not be	OB Bloom of Init	in. At home for	M		Yes 2 □ No	28f Location /5	Street and Ni	mher or Ru	ıral Route Number,	_
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	To the Hospitel or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical (hysician: To the best of miner: On the basis of and manner sta	examination ar								
	Fo the within Fo the	Me	29b. Signature and title of certifier	1)		2	29c. Licens	se number		29d. Date sig	ned (Month	h, Day, Year)	
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			30. Name and address of person who	completed cause of de	7 1 /	(Type, Print)	1.	We.		MN		1747	
			31. Date filed (Month, Day, Year)	32 Registra	r's Signature	Books	MIC	140-201	1200	1.00		11.0	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2001 08626 For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Paul Kenneth Hathaway 03 12 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Canklin Square If Under 24 Hrs. timore 8. Date of Birth (Month, Day, Year) Mar 6, 1933 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthplece (State or Foreign Country)
 Un k **Funeral** Days 1X M 2□ F 71 169-26-0240 Director Usuel Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h Counts or 28a-f show bernit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene Important: It lem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be redtilled at once. 1 ☐ Yes 2√ No MD Baltimore Rosedale Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8230 Pulaski Hgwy 3rd flr USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☐ No 1 ☐ Never Married 2 ☐ Married Hathaway, Paul Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: white þ 3 Widowed 4 XDivorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) unk College (1-4or 5+) unk truck driver sanitation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) unk unk Be 10 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) unk 19a. Informant's Name/Relationship (Type, Print) Daniel Bahr/friend 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) in State 22. Name and Address of Facility 21. Signature of Euneral Service Licensee Ronald S. Wade State Anatomy Board Baltimore, MD 21201 655 W. Baltimore Street mun Approximate Interval Between Onset and Death 23a. Part. Enter the diseas for complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Immediate Cluse (Final disease or condition resulting in death) Physician airway with Mycous Plugging Ubstruction of /Medical Due to (or as a consequence of) **Examiner** Preumonia Spiration Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed DUS Phagig
Due to (or as a consequence of) and that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, attending physician Nd Stage Be Completed by Physician/Medical Dementia IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) after death.

Director: After this certificate has been signed by the 3 in by the funeral director, page 2 should be detached 1 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Vascular Disease Ganggrene Right Foot 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗆 No 2 1 No 1 Tyes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification; To 1 Yes 2 No 1 (Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) To the 29b. Signature and title of dertifier 29c. License number 29d. Date signed (Month, Day, Year)) MAW 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Maw tranklin 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 8 MAR 2004 1 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 004 08627 1 - State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1 Decedent's Name (First, Middle, Last) Month 11:55 Kalfa arris **Physician** 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 5altimore 1 Cal 100 10 N/A If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Date of Birth (Month, Day) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** 1 □ M 2 🔀 F Director Infant Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County of Health and Mental Hygiene. item 23s or 28s-1 show item 27 to marked other than "neture!", or items 23s or 28s-1 show other traumatic event, it a Medical Examiliar mast be notified at 1 Yes 2 □ No HIMORE Funeral Director N/A 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 212 2054 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Never Married 2 Married filed within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: BIAC H þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Infant Infant Infant 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ont of Health a t: If item 27 le y or other tran BAHEMA - INDENALE TIEIA HARRI 20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 Removal from State permit. Page Department o Important: If any injury or Woodlawn Cemetery 3/17/04 Woodlawn, Maryland * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Sterling Ashton Schwab Funeral Home, Inc. B 736 Edmondson Avenue; Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician me /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner metap or Attending Physician: The law requires that the death certificate be executed 7) Due to (or as a consequence of): the attending physician a hed for use as the burial-P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months?
1 Yes 2 No
9 Unknown 4☐Pregnant at time of death 5 Other (specify) 9 Unknown been signed by the should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? 2 No 2□ No 1 Yes 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Yes 2 Wo Medical Certification: To 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation the 1 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 1/2001

n-112

31. Date filed (Month, Day, Year)

00

era

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Jesse F. Hines Jr. 1- State of Maryland / Department of Health and Mental Hygiene 19a, b per FH, Go29, 03/18/04hb Certificate of Death 04 - 184808629 AKG 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Year HEE MAN Jessie March /Medical 14. 2004 4:14 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner NIA Baltimore

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
(Month, Day, Year)

Months | Days | Hours | Min. John Hopkins Hospital 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 18 M 2□ F 218-51-6255 Director MO Usual Residence of Decedent 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-1 show event, the Madical Examiner must be notified at BA HO 1XYes 2 □ No mD Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 2422 MAdison 4.s.A 21205 or Items 23e 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: BIACK þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) NONC None 0 of Health and Mental Hygie Item 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Hines ဂ္ Irssie Smilh 11.45 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2261 Prentland Dr., Baltimore, MD 21234 19a. Informant's Name/Relationship (Type, Print)

Jessie F. Hines Sr. 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages
Department of H
Important: If ite
any injury or of cemetery, crematory or other place) 1 Burial 2 □ Cremation 3 □ Removal from State Kbutus MemPr 3-20-04 Anbutus 4 □ Donation ¬¬□ Other (Specify) 21. Signature of Fundral ervice Licensee 22. Name and Address of Facility
BeTIS EYNE 112911 C Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician THERMAL AND a SMOKE INHALATION /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine death certificate be executed resulting in death) Last Due to (or as a consequence of) burial Box 68760, physician Physician/Medical the as attending IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy for Month Year Day 4 Pregnant at time of death 5 Other (specify) ed by the a detached f 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by it Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 Yes 2 No 3 Probably 4 ☐Unknown been 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an s certificate ha of Vital 1 Yes 2 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation **Division** 1 □Natural 3:38 death. 14104 1 ☐ Yes 2 🗷 No VICTIM OF HOUSE 2 Accident after death 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide within 24 hours af To the Funeral D completely filled i RESIDENCE 22422 E MADISONST, BALTITIORE To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

**Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifie (Check only one)

DHMH 17 Rev 1/2001

RUBIO, ANA 31. Date filed (Month, Day, Year) MAR 1 8 2004

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

29b. Signature and title of certifier

32. Registrar's Signature (Assale)

Registrar

State

29c. License number

O.C.M.E.

29d. Date signed (Month, Dey, Year)

March 15, 2004

111 Penn Street, Baltimore, Maryland 21201

			1 - For State Registrar	State of Maryland	d / Depar <i>Certi</i>	tment of H ficate of I	lealth and M D <i>eath</i>		ene 2004	08630
S. 25	Physic /Medi		1. Decedent's Name (First, Middle, Last)	Julius	>		2. Date of Death Month	Day Year	3. Time of Death
	Examir Funeral Director		5. Social Security Number 6. Se	yview Medical	Center ast birthday)		Location of Death HINORE If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,)	4c. County of Death N /	
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Item 27 is marked other then "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner mark by notified at	To Be Completed by Funeral Director	10a. State 10b. County MARYLAND NI 10e. Street and Number	MONT STRE 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes. 2 No. If Yes. Give Year or Dates: (cation e completed) College (1-4or 5+)	16a. Deceden (Give kin life. DO M	BALT 101. Zip Code s Decedent of Hies, specify Cubar Yes 22 No t's Usual Occupa d of work done NOT use retired,	uring most of working the LUGRI 18. Mother's Name	2 4 10s 2 4 10s 2 4 16 16 16 (First, Middle, Ma	iden Sumame)	can Indian, etc. ACK industry FAMILIES
Baltimore, Ma	permit. Pages 1 and 2 s Department of Health an Important: If item 27 is eny injury or other trau		20a. Method of Disposition 1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens	R-BEY (SON) Removal from State Control Co	S37 ace of Disposition of the Charlest	N. LUZ on (Name of ory or other place DEMATO	ERNE A ORY 03-6 ory 03-6	VE, BAL 20 22-04 P 20 J JR	c. Location - City or T	J1205 own, State EMARYLAND AL HOME
68760,	Physician and Medical Examiner but students the private in the pri	edical Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that indiated events resulting in death) Last	Due to (or as a consequence). Due to (or as a consequence). Due to (or as a consequence).	ence of): +ract ence of):	- in fec		respiratory arrest		Approximate Interval Between Onset and Death
P.O. Box	res that the death certifica signed by the attending ph be detached for use as th	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pregnand Live birth 2 Fetal of dead Pregnant at time of dead Unknown	death 3□Ect ath 5□Ot	opic pregnancy her (specify)	n in Part I.	23e. Did tobac	23d. Date of deliver	Day Year
al Records	uicien: The law requires certificate has been sign rector, page 2 should be	Completed by	Hypertension	, Hypothyro				1 Yes 24a. Was an autopsy performed 1 Yes 2	2 No 3 Prob 24b. Were auto prior to coi death?	ably 4 Munknown psy findings available inpletion of cause of
Division of Vital Records,	shys this al dii	Certification: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Astural 5 Pending investigation 3 Suicide 6 Could not be determined		28b. Time of Injury	Other 28c. Injury: Work? M 1 76	at 20	e 5 Residence	t and Number or Rura	
	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Medical Ce	29a. Certifier (Clock of pone) 1 Certifying Physical Examite 29b. Signature and title of certifier	ician: To the best of my knowler: On the basis of examination and manner stated.	ledge, death oc on and/or invest	curred at the time gation, in my opin	nion, death occurred	nd due to the cause d at the time, date	·	the cause(s)
•	7	-	· Stony	Additional of the state of the	23a) (Type, Prin	D00 5	5334/	Mo	rch 16,	2004
1	Sta Registr	100	St n Du 31. Date filed Mark Day, Seas 2004	de K. M. D. Registrar's Signatu	49	40 Eas	lem Avai	e, Bultu	ucie, MD:	4224

Darryl Jordan 04 - 1875AKG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend State of Maryland Bepartment of Health and Mental Hygiene 2004

	0	C	2	1
Ĺ	18	O	J	1

J.		- State Registrar	Ce	rtificate of Death	Reg. No.	00001
Physi /Med		1. Decedent's Name (First, Middle, Las	E. Jordan		Date of Death Month Day Year Ch 15, 2004	3. Time of Death 2:30 P M
Exam		4a. Facility Name (If not institution, give		4b. City, Town, or Location of Death	4c. County of Dea	ith
		2715 Lauretta Ave	nue	Baltimore	NA	
Funera Directo		DI L- 11-1004	ex 7. Age (In yrs. last birthday, SM 2□F 7. Age (In yrs. last birthday, Yrs.	Months Days Hours Min	_(Month_Day, Year)G	ountry) conyland
and		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation		10d. Inside City Limits
the Marylan 28a-f ehow	Director	MD NA	BALTO			1 A Yes 2 No
e = 5	ire	10e. Street and Number	1	10f. Zip Code	10g. Citizen of What C	ountry?
ifh wi	<u></u>	2715 Laurella	i Ave	21223	USA	
ter dea items	Funerai	11. Marital Status	12. Was Decedent Ever in U.S. 13. Armed Forces?	Was Decedent of Hispanic Origin? (Specific Yes, specify Cuban, Mexican, Puerto Ric	y Yes or No- can, etc.) 14. Race - Am- Black, Whi	
036 ours af	by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 S Yes 2 □ No If Yes, Give Year or Dates: 1966 - 1966	1 ☐ Yes 2 ☐ No Specify:	Specify:	lack
21215-00 I within 72 hour liene. I then "naturel"	Completed	15. Decedent's Ed (Specify only highest gra	lucation 16a. Dece	dent's Usual Occupation a kind of work done during most of working	16b. Kind of Business	/Industry
7 ug e 14	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	DO NOT use retired)	Carper	stry
nd 21 Hygier th other th	ပ်	12	u	mpenter		1
be filed tal Hyg of othe	Be	17. Father's Name (First, Middle, Last)		18. Mother's Name (A	First, Middle, Maiden Surname)	
should be not Mental marked of marked of marked of marked of marked of the marked of t	ပ္	Nelson Jorda		Mary	C GONGON	
Mar nd 2 sh lith and 27 is m		19a. Informant's Name/Relationship (Do alalari ha	ing Address (Street and Number or Rural F	Poute Number, City or Town, State,	Zip Code)
es 1 and of Healt fitem 2		20a. Method of Disposition	20b. Place of Disp		e 20c. Location - City or	Town, State
Baltimore, bermit. Pages 1 at Department of Heamportant: If the may injury or othe		1 ☐ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Other (Specify	Hemoval from State	E. w. 1 May 13-22	-04 BATTO	Md.
Baltimo		21. Signature of Funeral Service Licen	Sea 2	2. Name and Address of Facility	Iton C. Dougla Culoh St. BAT	USS Funeral Style
		222 Part Fotor the disease or com	plications that caused the death. Do not en			Approximate
		shock, or heart failure. List only	one cause on each line.	tel the mode of dying, such as cardiac of t	espiratory arrest,	Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition resulting in death)	a Arteriosclerotic	Cardiovascular Dis	ease	
/Medica Examine		(esolary in death)	Due to (or as a consequence of):			
		Sequentially list conditions,	b			
be isi	in e	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Day to (or as a consequence of):			
eecuti and I-tran	Examiner	that initiated events resulting in death) Last	c. Due to (or as a consequence of):			
68760, ificate be execute g physician and as the burial-trans						
587 iicate phys	opposite		. d			
Box 68 eath certific	Z/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy		23d. Date of de	livery
P.O. Box 68760, hat the death certificate be executed by the attending physician and selached for use as the burial-transit	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		□Ectopic pregnancy □ Other (specify)	Month	Day Year
d bat i	4	Part II Other significant conditions of	ontributing to death but not resulting in the u	Inderiving cause given in Part I	23e Did tobacco use contribute to	o the cause of death?

To the Hospital or Attending Physician: The law requires that the death within 24 hours atter death.
To the Funeral Director: After this cartificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for to. ă Division of Vital Records, P.O.

þ

Completed

Be

2

Certification:

in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical examiner?

1⊠Xes 2 No

27. Manner of Death

1 Natural 2 Accident

3 🗌 Suicide

29a. Certifier

4 Homicide

1 🔲 Inpatient

28a. Date of Injury (Month, Day Year)

Hospital:

3 DOA

23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown

24a. Was an autopsy performed' 1 Yes 200 No

24b. Were autopsy findings available prior to completion of cause of death? 1 🗌 Yes 2 🗆 No

26. Place of Death Check only one

At scene

Other: 4 Nursing Home 5 Residence 6 MOther (Specify) 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

**Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

5 Pending investigation

6 Could not be determined

29c. License number

29d. Date signed (Month, Day, Year)

O.C.M.E.

March 16, 2004

M.13

111 Penn Street, Baltimore, Maryland 21201

State Registrar 31. Date filed (Month, Day, Year) 8

82. Registrar's Signature

2 ER/Outpatient

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

NUD

of seath (Item 23a) (Type, Print)

28b. Time of Injury

		1	For State Registrar	Stat	e of Mary	land / Depa <i>Cer</i>	rtmer <i>tificat</i>	t of He	alth and M eath		iene 2	004	08632
de	Physicia		Decedent's Name (First, Middle	e, Last)		Jone	26			2. Date of Deal Month 3 1.	Day	OO4	3. Time of Death 3:40p M
	/Medic Examin	al	Helen 4a. Facility Name (If not institution, give street and number) Millennium N.H.					4b. City, Town, or Location of Death Baltimore			4c. County of Deeth		
^	Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birt							f Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 9. B 3-15-08			place (State or Foreign intry)
	faryland		10a. State 10b. County 10c. City, Town or Location Md. NA Baltin									10d. Inside City Limits ★☆Yes 2 □ No	
	death with the Maryland ms 23e or 28a-f show rmust be notified at	Director	10e. Street and Number 3219 Belmont	Ave.			10f. Zi	Code 21216		1	10g. Citizen of What Country? USA		
	is within 72 hours after death with the Marylan jiene. Jehan "naturel; or Items 23e or 28a-f show the Maryleal Examiner must be notified at the Maryleal Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Mar 3 □ Widowed 4 □ Divorced	12. Was	Decedent Ever ed Forces? Yes 27 No es, Give r or Dates:	2▼ No ve 1 □ Yes 2 ▼No Specify:			ecify Yes or No- Rican, etc.) 14. Race · American Indian, Black, White, etc. Specify: Black			e, etc.	
1215-0036	within 72 hou ene. than "nature he Medical E	Completed	15. Deceder (Specify only higher Elementary/Secondary (0-12)	nt's Education est grade comp	(Give life. L		adent's Usual Occupation a kind of work done during most of workii DO NOT use retired) mestic			16b. Kind of Business/Inc Other Peop			
ana z	be filed Ital Hyg ed othe event,	o Be Co	7th grade 17. Father's Name (First, Middle, Last) John DeShield				18. Mother's Name (First, Middle, Maid Lillie いからい						
Maryland	har har 7 is		19a. Informant's Name/Relation Beulah DeShie		ister-ir		-		d Number or Aur				lip Code) L216
Baltimore,	Pages 1 and 2 nent of Health int: If item 27 in ury or other tra		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (3 □Remova	2	20b. Place of Dispo cemetery, cres	sition (Na matory or	me of		Date	20c. Locat	ion - City or	Town, State วัฬิก , Md .
Baltin	permit. Pages Dep riment of Important: If it any injury or o		21. Signature of Funeral Service		Cuas	22	2. Name a	F.H.	of Facility		more,	Mđ.	21202
	Physician /Medical		23a. Part1. Enter the disease, of shock, or heart failure. Lis Immediete Cause (Final disease or condition resulting in death)	a	that caused the e on each line.	death. Do not ent	tor the me	do of duing	cuch ac cardiac	or respiratory and	Dyc	ase	Approximate Interval Between Onset and Death
8760,	Examiner be executed bhysicien and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	oue to (or as a co	onsequence of):	Ar	nem	115				7426
.O. Box 68	ne death certifi the attending hed for use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unkngwn	1 <u>0</u>	es, outcome of p]Live birth 2 []Pregnant at tim] Unknown	Fetal death 3	⊒Ectopic ⊒ Other (pregnancy specify)			23d. Date of delivery Month Day Year		
s, P	uires that the signed by Id be detac		Part II. Other significant condit	tions contribution	ng to death but n	ot resulting in the u	underlying	cause giver	n in Part I.		obacco use /es 2 🗆 l		the cause of death?
of Vital Record		Completed								24e. Was autop perfo 1 Yes		prior to	utopsy findings available completion of cause of
n of Vita	ng Physician: The liter this certificate ha	To Be	25. Was case referred to medic examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pend	2 ER/Outpatie		OOA Other	at	th (Check only of ome 5 Residence 128d. Describe h	dence 6 [city)		
Division	To the Hospital or Attending Phwitin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Certification;	2 Accident inves	stigation	. Place of Injury building, etc. (· At home, farm, si Specify)	M treet, fact		es 2 No	28f. Location (S City or Tox		Number or Au	ural Route Number,
	e Hospital 24 hours a e Funeral l	edical C	29a. Certifier 1 Certify (Check only one) 2 Medical	al Examiner: O	To the best of n n the basis of ex nd manner stated	ny knowledge, dea kamination and/or is d.	th occurre	ed at the time on, in my opi	e, date and place inion, death occu	, and due to the rred at the time,	cause(s) ar date and pl	nd manner as lace, and due	s stated. e to the cause(s)
)	To the I within 2 To the I complet	Me	29b. Signature and title of certif	ier S and			2	9c. License	number G 6 4 1		Man	signed (Mont	7h, Day, Year)
	2		30. Name and address of person address of person and address of person and address of person and address of person address of person and address of person address of person and address of person add	on who complete	My 2	th (Item 23a) (Type	Print)	ckk	liver No	rck Ro	ad k	Baltin	me Maylal
	Si	tate	31. Date filed (Month, Day, Yea	8 2004	32 Registrar's	Signature	hand						41-01

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. mach 12 State of Maryland / Department of Health and Mental Hygiene 2004 For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2004 Month **Physician** March 12, George Kenneth Jones /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Towson Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Nov 1, 1929 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days 1X M 2□ F 74 218-26-4802 Maryland Director Usual Residence of Decedent 10a, State 10c. City, Town or Location 10b. County 28a-f show Item 27 is marked other then "netural", or Items 23a or 28a-f show other traumatic event, the Madical Example or must be notified at MD Baltimore Towson Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1207 Old Pylesville Road 21160 USA Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Never Married 2X Married 1 ☐ Yes 2 X No Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: white If Yes, Give Year or Dates: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then any injury or other traumatic event, Item one. Elementary/Secondary (0-12) College (1-4or 5+) insurance agent insurance 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental George Burnette Jones reba Adelva Allison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marlyn Jones/spouse 1207 Old Pylesville Road Whiteford, MD 21160 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ፟ ☐ Donation 5 ☐ Other (Specify) 21. Signature of Tyneral Sirve Sicensee pe/mit. State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Icen 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) P.O. nt conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 3 Probably 4 Unknown certificate has been si rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes To the Hospital or Attending Physician: the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence E John 1 🗌 Yes Medical Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of After 1 5 Pending Natural within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

08633

4:50 PMM

10d. Inside City Limits

Approximate Interval Between Onset and Aeath

Dav

29d. Date signed (Month, Day, Year)

Year

1 ☐ Yes 2 ▼ No

State Registrar 29b. Signature a

31. Date filed (Month, Day, Year)

8 2004

DHMH 17 Rev 1/2001

ORIGINAL

of death (Item 23a) (Type, Print)

32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 08634 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Year Physician 2004 /Medical 4b. City, Town, or Location of Deeth 4a Fecility Neme (If not institution, give street end number) 4c. County of Death Examiner 1708 W. ROGERS BALTIMORE If Under 1 Year | If Under 24 Hrs. | Hours | Min. 7. Age (In yrs. lest birthdey) **Funeral** Director Maryland Usuel Residence of Decedent parmit. Peges 1 and 2 should be filed within 72 hours aftar death with the Meryland Department of Haalth and Mental Hygiene. Important: If item 27 is marked other than "naturel", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examinar must be notified as 10a. Stete 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Funeral Director Maryland Worchester Bishopville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12623 Shell Mill Road 68 21813 USA 12. Wes Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes 2 D No
If Yes, Give Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White etc. 1 Never Merried 2 ☐ Married Saltimore, Maryland 21215-0020 1 ☐ Yes 21 ☐XNo Specify: Specify: Be Completed by white 3 Widowed 4 Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Child/Student 6th 17. Fether's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Surname) Theodore Johnson Pamela Penner 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 2 1 8 1 3 Terry Malcolm Foster Parent 12623 Shell Mill Rd 68 Bishopville, MD 20b. Place of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, State p□Burial 2 □ Cremation 3 □ Removal from State Evergreen Memorial Pk 3/19/04 Finksburg, MD 4 ☐ Donation 5 ☐ Other (Specify) Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road Baltimore, Maryland 21. Signature of Funeral Service License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one pause on each line. Approximate Interval Between Onset and Death **Physician** SIN LE Wedical Immediate Cause (Final disease or condition resulting in death) **Examiner** SIN by Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, Due to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en autopsy performed? Completed 1 ☐ Yes 2 ☐ No TLI Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No edical Certification: To Inpatient 2 ER/Outpatient 3D DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, this filled in by tha funaral 28a. Date of Injury (Month, Day 27. Manner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours efter death.

To the Funeral Director: Aftar t
completely filled in by tha funara 5 ☐ Pending investigation 1 Naturel 2 ☐ Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d Date signed (Month, Dev. Yeer) 29b. Signature and title of certifier 30. Name end address of person who completed ceuse of death (Item 23a) (Type, Print) 1708 W. ROGERS AATTAMORE, MUSINDE BARINADA G MT. WASHINGTON 31. Date filed (Month, Day, Year) 32. Registrer's Signeture State Registrar 1 8 2004

DHMH 16 Rev 6/95

Cameron Johnson 04-01851 RJ

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien

08635

		•	1 - State Registrar		Ce	rtificate of	Death		Reg. No.	004	00000
	Dhysisi	200	1. Decedent's Name (First, Mid		/			2. Date of D	eath Day	Year	3. Time of Death
	Physici /Medio		CAMERO	71	Johnso.	11		March	14,	2004	04:28 A.M
	Examir		4a. Facility Name (If not institut				r Location of Death)	4c. 0	County of Death	0 10 11 11
		М		ns Hospital			imore If Under 24 Hrs.	100.40		IV/A	
	Funeral		5. Social Security Number	6. Sex 7. Age	e (In yrs. last birthday) Yrs.	Months Days	Hours Min.	8. Date of B	Day, Year)	Cou	place (State or Foreign intry)
	Director		Usual Residence of Decedent					02 19-	04	n	и В ·
	yland		10a. State 10b. Coun	ity /	10c. City, Town or L	ocation					10d. Inside City Limits
	Mar.	tor	m.D.	N/A.	BAI	T. more	,				1 ØYes 2 □ No
	death with the Maryland ms 23a or 28a-f show	Director	10e. Street and Number			10f. Zip Code				en of What Cou	•
	23a	rai	2122 E.	MAdison		-	205			1.5.A.	,
	tems tems	Funeral	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.S. 13.	Was Decedent of H If Yes, specify Cub	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No Ricen, etc.)	10-	 Race - Ameri Black, White 	
0000	n 72 hours after death with the Marylan "natural", or Items 23a or 28a-1 show iolical Examilier roas bu notified at	by F	1 Never Married 2 M 3 Widowed 4 Divorc	If Yes, Give	No	1□Yes 2010	Specify:		5	Specify: B	Ack
3	hour			ent's Education	16a, Dece	dent's Usual Occup	pation		16b. Kin	d of Business/Ir	ndustry
<u> </u>	n na	Completed	(Specify only high Elementary/Secondary (0-12	hest grade completed)	(Give	kind of work done DO NOT use retired	during most of wor	king			,
7	d with	E	Elementary/Secondary (0°12	College (1-4013	77)	None			1	Vonc	
<u> </u>	al Hy lothe	Be C	17. Father's Name (First, Middle	1			18. Mother's Nan	ne (First, Middl	le, Maiden S	Sumame)	
<u>a</u>	Ment Ment arked	10 L	CourNey	Johnsons			KiRby	01/	Smi	Th	
a	2 sho and is ma		19a. Informant's Nam - elatio	nship (Type, Print)	19b. Maili	ing Address (Street	1	1	^		
e G	s 1 and f Health item 27 other to		HLGEA C	RAY	650		IDRIAK	Date LW.	HM		110.21401
	9°2 = 5		20a. Method of Disposition 1 ABurial 2 Crematio	n 3 Removal from State	20b. Place of Disponentery, cre	matory or other place	ce)			ation - City or T	
ащто	e e e		`4 □Donation 5 □Other		HIBU	Tus Mem	PR 3-2	0.04	Hrb	whus	md.
e D	permit. Departi		21. Signature of Fuheral Service	ce Licensee	2	TUS Mem 2. Name and Addre	FUNEXA	1 Home	<i>></i>	w. 1 2 13	,
			23a. Part1. Enter the disease,	or complications that causes						140104	Approximate
			shock, or heart failure. L	ist only one cause on each lin	ne.	tor the mede or dyn	ig, 50011 25 021 520	or respiratory	arrost,		Interval Between Onset and Death
× 1	Physician /Medical		disease or condition resulting in death)		INHMATIC	ON AND	THERMA	H IN	TVRIE	3	
	Examiner			Due to (or as	a consequence of):						
		ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence of);						
	d ansit	ᇤ	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	1							
<u></u>	exection and itself	Examiner	resulting in death) Last	Due to (or as	a consequence of):						
09/89	te be ysicié ne bu	cal		d							
20	rtifica ng ph as th	Medical	IE ESTATE								
X O D	death certificate be executed e attending physicien and nd for use as the burial-transit	-	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 Live birth	of pregnancy 2 Fetal death 3	☐Ectopic pregnancy	f		23	3d. Date of deliv	very Day Year
	D 0 D	hysician	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at 9☐ Unknown	time of death 5[Other (specify)				MONIT	Day Teal
Z.	requires that the death ce een signed by the atlendi hould be detached for use	Q.	Part II. Other significant cond	itions contributing to death h	ut not resulting in the o	inderlying cause an	en in Part I	23e Did	tobacco us	e contribute to	the cause of death?
က်	w requires that been signed be should be deta	l by	T dit ii. Olio olgiiii olio	the continuous graduation	at not rooming in the c	andonying daddo giv	on an exert		Yes 2		bably 4 Dunknown
Ö	peen	Completed									######################################
Hecords	e la has	mpi						24a. Wa auto per	s an opsy formed?	prior to co	opsy findings available empletion of cause of
	ician: The certificate ha		GE 111					1☐ Yes	2 No	1 🗌 Yes	2 No
Vital		o Be	25. Was case referred to medi examiner? NOTE: See 1 No.	Hospital: 1 Inpatie	ent 2 X ER/Outpatie	oth 30 pos Oth	er:				4.1
Ö	Phys or this aral dii	H	27. Manner of Death	28a. Date of Injur	ry 28b. Time o	of 28c. Injur	y at	28d. Describe		Other (Speci	77)
0	Attending I ir death. ector: After by the funer	tioi	1 Natural 5 Pen-	ding (Month, Day stigation 3/14/04	y Year) Injury 3:38	A M 1□	k? Yes 2.⊠No	VICTIM	of h	GUSE F	FIRE
UNISION	I or Attendi after death. Olrector: A I in by the fu	ifica	3 ☐ Suicide 6 ☐ Cou	ld not be 28e. Place of Injuriding	ury - At home, farm, st c. (Specify)			28f. Location	(Street and own, State)	Number or Rur	al Route Number, M
5	s afte	Certification:	4 [] Homicide	RESIDE						ADISON	ST, BALTIMORE
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by		29a. Certifier 1 Certification Check only 2 Madic	ying Physician: To the best at Examiner: On the basis of	of my knowledge, deal	th occurred at the tir	ne, date and place	, and due to the	e cause(s) a	and manner as s	stated.
	the H in 24 the F iplete	ledical	one)	and manner sta	ated.			nou at the time			
	To To	Σ	29b. Signature and title of certi	fier .		O.C.N				signed (Month, 15, 20	
	'n.		1 Ques			3.0.1				10, 20	
	D		30. Name and address of pers	on who completed cause of d	leath (Item 23a) (Type,	Print) 111 Po	enn Stree	et, Balt	timore	, Mary	Land 21201
	Sta	ate	31. Date files (Month) Dag. Mg.		ar's Signature	8,					
	Regist		MAN I O Z	UU4 JAMESES	A A PARTY	Secret 1					

Registrar

			1 - For State Registrar	State of Maryland	/ Depa	irtment of H tificate of L	ealth and M Death	Reg	g. No.	08636
	Physici	an	Decedent's Name (First, Middle, Last)	1 -	_	0		2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give st		JONE		Location of Death	March	4c. County of Deat	1710 M
	Examin	er	Augsburg Lutheran			Wood1a			Balti	
	Funeral Director		5 Social Security Number 6. Sex	M 2□F 7. Age (In yrs. la.	st birthday) 6 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, July 27,	Year) 9. Birti Co 1917 Ma	nplace (State or Foreign untry) ryland
	pu ,		Usual Residence of Decedent 10a. State 10b. County	10c City	Town or Lo	cation				10d. Inside City Limits
	e Maryla a-f shov lifted at	ctor	MD Baltin		Whit			Ţ		1 ☐ Yes 2 No
	3a or 28	I Director	10e. Street and Number 2 H Beeson Court			10f. Zip Code	236	10	g. Citizen of What Co United S	
မှ	I within 72 hours after death with the Maryland lien. I then "natural", or Hems 23e or 28e-f show the Medical Exame or must be notified at	Funeral		2. Was Decedent Ever in U.S. Armed Forces? 1XX es 2 \(\) No	1		spanic Origin? (Spen, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White	e, etc.
-003	Phours a stural', o	ed by	3 Widowed 4 Divorced 15. Decedent's Educ	If Yes, Give Year or Dates: '41-'	16a. Deced	l Yes 2 No	Specify:	10	Specify: W	hite
1215	within ene. then	Completed	(Specify only highest grade Elementary/Secondary (0-12) 12	College (1-4or 5+)	(Give lite. l	kind of work done do OO NOT use retired Machinis		ng	Bethlehe:	m Steel
and 2	be filed stal Hyg od othe event,	Be	17. Father's Name (First, Middle, Last) Howard C. Jones				18. Mother's Name Dorothea		aiden Sumame)	
Baltimore, Maryland 21215-0036	s 1 and 2 should by I Health and Menta Item 27 Is marked other treumatic e	P.	19a. Informant's Name/Relationship (Typ Louise S. Jones (Wi		19b. Mailir 2 H	g Address (Street a Beeson Co	and Number or Rura ourt Bal	A Route Number, Ltimore,	City or Town, State, 2 Maryland	(ip Code) 21236
more,	00		20a. Method of Disposition XXBurial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	movel from State	netery, crer	sition (Name of natory or other place Cemetery	9)	100	Oc. Location - City or Balitmore,	
Balti	permit. Page Department Important: It any injury o		21. Sign Les of Funeral Service License	le link			s of Facility Ppel Func ir Road		e, Inc. ore, Maryl	and 21206
	Physician		23a. Part1. Enter the disease, or complice shock, or heart failure. List only one immediate Cause (Final disease or condition	ations that caused the death. e cause on each line.			g, such as cardiac o		st,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death) Sequentially list conditions, b.	Due to (or as a conseque						7
	ecuted and -transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque		,				
68760,	icate be executed physician and s the burial-transit	edical E	d.							
P.O. Box 6	The law requires that the death certificate be executed tae been signed by the attending physician and age 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	ic. If yes, outcome of pregnand 1 Live birth 2 Fetal of 4 Pregnant at time of dea 9 Unknown	leath 3	Ectopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year
	uires that n signed by Id be deta	þ	Part II. Other significant conditions conf	ributing to death but not result	ing in the u	nderlying cause give	en in Part I.		acco use contribute to : 2 ∰No 3 ☐ Pri	the cause of death?
of Vital Records,	The law require ate has been sin page 2 should I	Completed						24a. Was an autopsy perform	ed? prior to death?	topsy findings available completion of cause of
/ita	icien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	ospital:		Oth	26. Place of Death			
of \	Physicien: r this certific ral director,	.T	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 Inpatient 2 E	R/Outpatier 8b. Time of		4 pursing Ho	me 5 🗌 Residen 28d. Describe how	ice 6 Other (Spec	cify)
Division	tending Physicien: leath. tor: After this certifics the funeral director, p	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(Month, Day Year)	Injury	M 1 🗆 '	Yes 2 □No			and Double Mumber
Divi	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune		4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ie, iaim, str	eet, ractory, office		City or Town,	eet and Number or Ru State)	iai nobie vuilbei,
	ne Hospital 24 hours ne Funerel pletely filled	edical		ician: To the best of my know er: On the basis of examination and manner stated.						
	To the within 2 To the complet	×	29b. Signature and title of certifier	\	_	29c. License			d. Date signed (Montl	
	`		•	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \			737573	>	March 15	1,7004
	O		30. Name and address of person who con	- 11	23a) (Type,	Print) Reiste.	stem 1	MD Z	1136	
	Sta Regist	ate	31. Date filed (Month, Day, Year)	32 Registrar's Signatu	re As	all)				

KAUFMAN MARKIE Baltimore, Maryland 21215-0036

Box 68760,	
P.O.	
Records,	
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ision o	

	-	For State Registrar AMEND ITEM #	State of	f Maryland R G829 <mark>3/</mark> 3	l / Depa 18 /0⊈<i>e</i>}	irtment of <i>Hificate o</i>	Health a	and Me	ental Hy	giene Reg. No.	200) 4	08637	
		Decedent's Name (First, Middle, La					-		2. Date of De	ath			3. Time of Death	
Physicia		Marie A. Kaufma		MARCH OF ZOON 1725M										
/Medica Examine		4a. Facility Name (If not institution, giv University Spec			4b. City, Town Balti	4c. County		County of I	of Death					
Funeral Director		5. Social Security Number 6. S 579-42-4133	Sex I□M 2∭TF	7. Age (In yrs. Ia 70	st birthday) Yrs.	If Under 1 Yes Months Day		24 Hrs. Min.	8. Date of Bir (Month, Da Aug 4,	y, Year)		Country	ce (State or Foreign y) sylvania	
D .		Usual Residence of Decedent		10c. City.	Town or Lo	cation						100	d. Inside City Limits	
show	10a. State 10b. County 10c. City, Town or Location Towson											1 ☐ Yes 2X No		
and within 7 indus are dean with the maryand in Hydone. Ital Hydone. Inatural, or items 23a or 28a-f show event, the Medical Examinar must be recitived at	Director	106. Street and Number								10g. Citizen of What Country?				
23a or ust be		111 West Road				2	21204				USA			
ms 2	Funeral	11. Marital Status	12. Was Dece Armed Fo	edent Ever in U.S	i. 13. V	Vas Decedent of Yes, specify C	f Hispanic Original	gin? (Spe	cify Yes or No	p-	14. Race -	Americar White, et		
or ite	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes If Yes, Giv Year or D	2 DXNo ∕e		I□Yes 2⊠N		.,	,		Specify:	whi		
"natural"	ted	15. Decedent's E (Specify only highest gr	ducation		16a. Deced	lent's Usual Occ	cupation	t of workin	a	16b. Ki	ind of Busin	ess/Indu	stry	
d other then "natu event, the Medical	Completed	Elementary/Secondary (0-12)	College (1	-4or 5+)	life. L	kind of work dot OO NOT use ret	ired)		3					
3	Co	12	4			artist	1- 10 Motho	r'a Nama	(First, Middle	desi				
90	Be	17. Father's Name (First, Middle, Last)			un	K 18. Moule	n S Name	(First, Middle	, waigen	Sumamer		unk	
matic	은	19a. Informant's Name/Relationship	Туре, Print)		19b. Mailin	g Address (Stre	et and Numbe	er or Rura	Route Numb	er, City o	r Town, Sta	ite, Zip C	>ode)	
Tran.		Verna Martin/fr			724	Camber1	y Circl	Le B7	Towso	n. M	D 21:	204		
othe	18	20a. Method of Disposition	_	CA	ace of Dispo	sition (Name of natory or other p			ate		cation - Cit		n, State	
ry 0 <u>r</u>		1 ☐ Burial 2 ☐ Cremation 3 ☐ `4 ☐ Donation 5 ☒ Other (Speci		State	o.o.y, o.o									
eny injury or other traumatic event, ILE Me QDCB.		21. Signatura Figure (A) Signatura Lice	nsee de / 1	regtor	S S	Name and Add tate Ana altimore	dress of Facility E	y Board 2120	655 W	. Bai	ltimo:	re Si	treet	
		23a. Part 1 Enter the disease, of con	plications that of	aused the death.						ırrest,			Approximate	
		shock or heart failure. List only one cause on each line. Immediate Cause (Final											nterval Between Onset and Death	
cian lical		disease or col dition resulting in death) a. Due to (or as a consequence of):									+-			
er		Agghma												
	jer	Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Cause (Disease or injury Sei Zwel 2006)												
	Examiner	Cause. Cities Unidentifying Cause (Disease or injury that initiated events c. Sei zwe disease												
	Exa	resulting in death) Last Due to (or as a consequence of):												
	dlcal	•	d									- 8		
	0	IF FEMALE:								1	- 50			
	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) 9 Unknown							23d. Date of delivery Month Day Year					
		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								use contribu	ite to the			
	d by	1 Yes 2 No								□No 3[☐ Probal	bly 4 Onknown		
	Completed						·····		24a. Was auto perf	psy ormed?	prio	r to comp th?	sy findings available pletion of cause of	
1								(5	1 Yes	2/Q No	1	Yes 2	No No	
5	o Be	25. Was case referred to medical examiner?	Hospital:	Inpatient 2□	ER/Outpatier	nt 3 DOA	Othor		(Check only ne 5 ☐ Res		6 □Other	(Specify)		
3	-	1 Yes 2 Nanner of Death	28a. Date	of Injury	28b. Time of	f 28c. Ir	njury at		8d. Describe			эреспу)		
2	tion	1 Natural 5 Pending 2 Accident investigation		th, Day Year)	Injury		Vork? □Yes 2□	No						
y the	fica	3 ☐ Suicide 6 ☐ Could not	286. Place	of Injury - At ho		eet, factory, offi	ce	2	8f. Location City or To	(Street ar	nd Number	or Rural	Route Number,	
	Certification:	4 Homicide	bulla	ing, etc. (Specify)				City of To	iwii, State	")			
100	edical (29a. Certifier 15 Certifying P (Check only one) 15 Medical Exa	miner: On the b	e best of my know easis of examinat ener stated.	wledge, deat ion and/or in	h occurred at the vestigation, in m	e time, date ar ny opinion, dea	nd place, a oth occurre	and due to the	cause(s , date and) and mann d place, and	er as stai	ted. :he cause(s)	
completely filled in by the funeral director, page 2 should be detached	Me	29b. Signature and title of certifier					ense number			29d. Da	te şigned (/	Month, D	ay, Year)	
			-			(Z)	5271	49			5 9	100	۲	
		30. Name and address of person who												
		ALETTA ANN FRAIZER					BALTIMOR	E,MD.						
Sta		31. Date filed (Month, Day, Year)	32 F	Registrar's Signat	ture A	sele!								
Registi	ar	MAR 1 8 20	104	35.05 F.S	100	-								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 8 per Th 8845 7-15-05 vt. State of Maryland / Department of Health and Mental Hygiene 2004 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Ian A. M. 2004 3 /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Rosedale Franklin Squard Hospital If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 9. Birthplace (State or Foreigh Country) Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 1 M 2 □ F Months 21203 2621 Director April 18, 1917 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow Examiner must be notified at 1 Yes 2 No Maryland Baltimore Directo Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ō 103 Sunflower Lane 21220 USA , or items 23e death Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Pages 1 and 2 should be filed within 72 hours after t ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: 3 ☑ Widowed 4 ☐ Divorced "netural", 15. Decedent's Education (Specify only highest grade completed) Health and Mental Hygiene.
om 27 is marked other then "netusther traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Senior Store Keeper Baltimore City 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Calvin Kirby Marie A. Diehl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is eny injury or other trau once. William August Kirby (Son) 103 Sunflower Lane, Baltimore, MD 21220 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Commetery, Cremation 3 Removal from State Ridge Memorial Park March 19, 2004 Elkridge, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Loring Byers Funeral Directors Kellner 8728 Liberty Rd. Randallstown,MD 21133-4784 M00333 23a. PM1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) **Physician** Cardiac arr /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, any backing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospitel or Attending Physician: The law requires that the death certificate be executed and burial-trag Due to (or as a consequence of): attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 Other (specify) detached 9 Unknown signed by I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ all 1 Yes 2 1 No 3 Probably 4 Unknown Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 1 No director 25. Was case referred to medical 26. Place of Death Check on one Hospital: 1 | Inpatient 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of After 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division of Vital Records, P.O. Box 68760.

Ir

To the

Medical

State Registrar

29b. Signature and title of certifier

(Check only

who completed cause of death (Item 23a) (Type, Print) Baltima 32. Registrar's Signature

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number D54802 29d. Date signed (Month, Day, Year)

03-16-04

State of Maryland / Department of Health and Mental Hygiene 004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth **Physician** Lee Kert 15, March 2004 9:25 AM /Medical 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Manor Care Nursing Home Baltimore County Ruxton If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** 1√2M 2□ F Months 79 Yrs. Pennsylvania Director 187-12-7281 1924 Usuel Residence of Decedent permit. Pages 1 and 2 should be filled within 72 hours effer death with the Maryland Depertment of Heelih end Mentel Hygiene. Important: If Nem 27 is marked other than "natural" ---- any injury or other traumetic event. 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits X Yes 2 □ No Funeral Director Maryland N/A Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 3358 Chestnut Avenue 21211 USA 12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ※ ᠓ No If Yes, Give Year or Dates: WWII Was Decedent of Hispenic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Merried Married 1 ☐ Yes 2x No Specify. δ Specify 3 Widowed 4 Divorced white WWII Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Contractor Home Improvement 11th17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Edward Lee Kert Marie 19a. fnformant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore Maryland 21211 Edward Kert Son 3841 Falls Road Apt. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Baltimore-Washington 3/20/04 Laurel, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility
Burgee-Henss-Seitz Funeral Home, 21. Signature of Funeral Service, Licensee 363Ĭ Falls Road Baltimore, MD 21211 23a. Part . Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician fmmediate Cause (Final disease or condition resulting in death) riviedical CARCINON Examiner Physician/Medical Examiner ed by the ettanding physicien and datached for usa as the burial-transit or Attending Physician: The lew requires that the death certificate be axecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of) Division of Vital Records, P.O. Box 68760, Due to (or as e consequence of) Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? within 24 hours after death.

To the Funeral Director: After this cartificata has been signed by completely filled in by the funerel director, page 2 should be datac 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Be Completed by 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? 2 No 1 🗆 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 28a. Dete of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 ☐ Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide edical 29a. Certifier 1) Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the besis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) end manner steted. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Yeer) cerm 30. Name end eddress of person who completed cause of deeth (Item 23a) (Type, Print) GHIL 1600 31. Date filed (Month, Dey, Yeer) 32. Registrer's Signeture State

DHMH 16 Rev 6/95

Registrar

MAR 1 8 2004

State of Maryland / Department of Health and Mental Hygiene 1 08640 For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1 Decedent's Name (First, Middle, Last) Month **Physician** 3 15 2004 6:32 Ann Marizetta Lowers /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner Balto Milford Manor Pikesville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 ☐ M 2 🔏 F Yrs 71 10-18-1932 212-34-5485 N.C. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23s or 28s-f show any injury or other traumatic avent. Its Medical Esercing. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 XNo Director Balto Suitland 10g. Citizen of What Country? 10f. Zin Code 10e. Street and Number 20746 USA 4100 Suitland Road Funerai 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2X No Black. Specify: If Yes, Give Year or Dates: δ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Dept of Navy 12th grade years Editional Assistant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Otis Hughes Annie Lee Richardson ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Jeffrey R. Lowers - Son 1748 Blue Crayon Street Newbury Park, Ca 91320 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition W Burial 2 ☐ Cremation 3 ☐ Removal from State Arbutus Memorial Pk 3-23-2004 Arbutus, Md * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility March F/H West 21. Signature of Funeral Service Licensee 4300 Wabash Avenue Balto, Md 21215 eble 10 23a. Part1. Enter the disease, or emplications that a used the death. Do not enjet the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Vist only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 10 cummu **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (of as a consequence of). Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): of Vital Records, P.O. Box 68760. signed by the attending physicien Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year ō in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ should be 3 Probably 4 Danknown 1 ☐ Yes 2 ☐ No Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has page 2 2 ☑ No 1 Yes 2 No or Attending Physician: director. 26. Place of Death (Check only one) Be 25. Was case referred to medical Hospital: 1 ☐ Inpatient Other: 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) completely filled in by the funeral 28b. Time of 28d. Describe how injury occurred After Division 1 Natural Injury 5 Pending 1 ☐ Yes 2 🗌 No death. 2 Accident investigation Director 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours after To the Funeral Dire To the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certify 7569 ause of death (Item 23a) (Type, Print) 30. Name and address of who completed Neene lttlemes 32. Registrar's Signature 31. Date filed (Month, Day State MAR 1 8 2004 Registrar

			1 - State Registrar	State of	Marylan		irtment of	Health and N		giene Reg. No. 200	4 08641	
	Physici		1. Decedent's Name (First, Middle, Last Minnie Mae		s				2. Date of De Month		3. Time of Death 8:35 am ^M	
	/Medic Examir		4a. Facility Name (If not institution, give GREATER BALTIMORE			ER	4b. City, Town	, or Location of Death		4c. County of De.	ath	
	Funeral Director		5. Social Security Number 6. Se 214-22-2098		Age (In yrs. I		If Under 1 Ye Months Day		8. Date of Bir (Month, Da Sept	th 9. Bi	Country) Carolina	
	Maryland f show	or	Usual Residence of Decedent 10a. State 10b. County Maryland Balt	imore	10c. City	, Town or Lo	cation kton				10d. Inside City Limits 1 ☐ Yes TNo	
	death with the Maryland ms 23a or 28a-f show	Direct	10e. Street and Number 20000 York Road				10f. Zip Code			10g. Citizen of What C		
Q g		by Funeral Director	11. Marital Status 1 Never Married 2 Married	12. Was Decede Armed Force 1 □ Yes 🛠	∍s?		Vas Decedent of Yes, specify C	1120 f Hispanic Origin? (Spuban, Mexican, Puerto	ecify Yes or No Rican, etc.)	USA 14. Race - Am Black, Wh		
5-003	ours Feri	eted by	% Widowed 4 □ Divorced 15. Decedent's Edu (Specify only highest grad	If Yes, Give Year or Date cation e completed)	es:	16a. Deced	ent's Usual Occ	cupation	ina	Specify: 16b. Kind of Busines:	white s/Industry	
12121	be filed within 72 h tal Hygiene. d other then "natu event, the Medical	Completed	Elementary/Secondary (0·12) 5 t h 17. Father's Name (First, Middle, Last)	College (1-4	or 5+)		aver	ne during most of work		Rocklin	Industrie	
Sylanc	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Man	To Be	Wylie Dority 19a. Informant's Name/Relationship (T)	no Printl		105 14-75-	- 414 (0)	Mary	Rebecc	Maiden Sumame) a Martin		
E. Ma			Lisa Williams 20a. Method of Disposition	Daug		3412		Avenue		in, City or Town, State, imore, Ma 20c. Location - City or		
Le U	Pages nent of ant: If I		1		te Ce	metery, cren lane y	natory or other p Valle	y Mem. 3, ardens			m, Marylan	
Ba	permit. Departr Importa any inje		Jeace H Car	penter	sed the death	B	urgee- 631 Fa	Henss-Se: 11s Road	itz Fur Ba	neral Hom Itimore,	e, Inc. MD 21211	
•	Physician /Medical		23a. Part 1. Enter the disease, or compishock, or heart tarture. List only of Immediate Cause (Final disease or condition resulting in death)	ME	TASTA	TIC	BLADD		UCER		Interval Between Onset and Death	
	Examiner	ler	Sequentially list conditions, if any, leading to immediate)	as a consequ							
· o	be executed sician and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or	as a consequ	ence of):						
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.O. Box	The law requires that the death certificate be executate has been signed by the attending physician and page 2 should be detached for use as the burial-trar	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown		1 2 ☐ Fetal t at time of de	death 3 🗌	Ectopic pregnar Other (specify)			23d. Date of de Month	livery Day Year	
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il Reco	The law retate has be page 2 sho	Completed							24a. Was a autop: perfor	med? prior to death?	utopsy findings available completion of cause of	
	Attanding Physiclan: Teath. c death. sector: After this certifica	To Be	27. Manner of Death	ospital: 1 ⊠Jnpa 28a. Date of li (Month, i	atient 2 E	R/Outpatient 28b. Time of Injury	3□ DOA C	26. Place of Death ther: 4 Nursing Hours	me 5 ☐ Resid	ence 6 Other (Spe	cify)	
× Division of	io Dire	Certification:	1 Suicide 4 Homicide 1 Setup	28e. Place of		ne, farm, stre		Yes 2 No	28f. Location (S City or Tow	treet and Number or Re n, State)	ural Route Number,	
J	Hospital 24 hours a Funeral I etely filled	Medical Ce	29a. Certifier (Chack only one) 1. Certifying Physical Examination (Chack only one)	ician: To the be er: On the basis and manner	s of examination	riedge, death on and/or invi	occurred at the	time, date and place, a opinion, death occurr	and due to the c ed at the time, d	ause(s) and manner as ate and place, and due	s stated. to the cause(s)	
	To the within 2 To the comple	Me	29b. Signature and title of certifier	Ch C		2		se number		9d. Date signed (Mont	h, Day, Year)	
	10		30. Name and address of person who co	mpleted cause o		23a) (Туре, F	*	ET, SUITE			21204	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Regi	strar's Signatu	ire	71.66	-, -0116		- The Stander of Control	117770	

			1 - For State Registrar	State of Marylan	d / Dep <i>Ce</i>	artment of I	Health and M Death		Reg. No.	08642
	Physici /Medio Examir	cal	1. Decedent's Name (First, Middle, La	lebo(1		4b. City, Town, o	or Location of Death	2. Date of De Month	Day Yea	4 545 pm
	Funeral Director		Usual Residence of Decedent 10a. State 10b. County	1□M 2⊠F 90	Yrs. y, Town or Le			8. Date of Bir (Month, Da	BeHir th y, Year) 9. E	Sirthplace (State or Foreign MD) 10d. Inside City Limits 1 Yes 2 No
	ith the Marylar or 28a-f show	Directo	10e. Street and Number	IMORE	BALI	10f. Zip Code	01000		10g. Citizen of What	Country?
936	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or iteme 23a or 28a-f show sayl jolury or other traumatic event, its Modical Examination units invitied at once.	by Funeral Director	2809 LAURELWOOD 11. Marital Status 1 Never Married 2 Married 3 W Widowed 4 Divorced	COURT 12. Was Decedent Ever in U. Armed Forces? 1		Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ※ No	21209 Hispanic Origin? (Span, Mexican, Puerto	ecify Yes or No Rican, etc.)	14. Race - Ai Black, W Specify:	U.S.A. merican Indian, hite, etc. WHITE
21215-0036	d within 72 hou giene. or then "neture It e Madical E	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of work	ing	16b. Kind of Busines	ss/Industry
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-	and 2 sho eaith and I m 27 is me		19a. Informant's Name/Relationship (ADRIENNE BLUMBER	G / DAUGHTER	2904	LIGHTFO	OT DRIVE	- BALTI	MORE, MD 2	1209
Baltimore,	Pages 1 ment of Hi ant: If iter lury or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Special	Removal from State HEB	REW YC		CEM. 3/16	The second second	20c. Location - City WOODLA	WN, MD
Ball	permit. Depart Import any inj		21. Signatura Funeral Service Licer	Juger	- 8		TERSTOWN	ROAD -		., INC. , MD 21208
	cate be executed hysicien and hysicien and hysicien and his buriat-transit	icai Examiner	shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undeath Cause (Disease or nour) that initiated events resulting in death) Last	b. Due to (or as a conseq c. Due to (or as a conseq d.	uence of):	cilvee				Interval Between Onset and Death
O. Box 68	ath certifi attending for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ■ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d	Ideath 3[□Ectopic pregnanc □ Other (specify) _	у		23d. Date of o	lelivery Day Year
ds, P.O.	uires that the de signed by the a Id be detached	ρ	Part II. Other significant conditions of	contributing to death but not res	ulting in the u	inderlying cause giv	ven in Part I.			to the cause of death? Probably 41—Unknown
I Records,	The law require sate has been sig page 2 should t	Completed						24a. Was autop perio 1 ☐ Yes	prior to the second sec	autopsy findings available o completion of cause of ?
on of Vital	Physiclan: this certific ral director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Hospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatie 28b. Time o Injury	f 28c. Inju		me 5 Resid	ene) dence 6 ⊡Other (S) now injury occurred	pecify)
Division	To the Hospitei or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	Certification:	3 Suicide 6 Could not be determined		ome, farm, st	reet, factory, office		28f. Location (S City or Tox	Street and Number or won, State)	Rural Route Number,
	To the Hospitei within 24 hours a To the Funerai I completely filled	Medical (29a. Certifier 1 Certifying Pt (Check only one) 2 Medical Example	hysician: To the best of my kno miner: On the basis of examina and manner stated.	wledge, deat tion and/or in	h occurred at the ti vestigation, in my o	me, date and place, opinion, death occurr	and due to the red at the time,	cause(s) and manner date and place, and d	as stated. ue to the cause(s)
	To th To th comp	X	29b. Signature and title of certifier	1 als MD		29c. Licens			29d. Date signed (Mo	
	6		30. Name and address of person who	June H I) completed cause of death (Item	n 23a) (Type,	Print)	53150			69, 2004
¥	Sta Registr	_	5 H HWW N M A CA 31. Date filed (Month, Day, Year) MAR 1 8 2004	GUPFA 5	15 B	RIGHT	FIELD	1CD	LUTHER	VILLE MD

State of Maryland / Department of Health and Mental Hygien 004 08643 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Dorothy Margaret Listman March 12, 2004 1:40 A /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Augsburg Lutheran Home Baltimore Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 □ M 2 F 89 Yrs. Director 216-48-4800 9/28/1914 Maryland Usuel Residence of Decedent 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examinar must be notitied at 1 Yes 2 No Director Baltimore Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zin Code 6811 Campfield Road Apt. 10P 21207 U.S.A. filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: White ۾ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Johns Hopkins Hospital Secretary permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If item 27 Is marked oth any injury or other traumatic event 2008: 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lawrence Hetzner Anna Margaret Friedel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth Listman 2006 Hunt Field Ct. Fallston, Maryland 21047 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ♥ Burial 2 Cremation 3 Removal from State 3/16/04 Gardens of Faith *4 □ Donation 5 □ Other (Specify) Baltimore, Maryland 22. Name and Address of Facility Miller-Dippel Funeral Home Inc. 21. Sign ture of Funeral Service Licensee 23a. Pent Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shook, or heart failure. List only one cause on each line. 6415 Belair Road Baltimore, Maryland 21206 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Atheroscierotic Cardiovascular Disease Physician years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner and Il-transit Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician a for use as the burial-Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 4□Pregnant at time of death 5 Other (specify) signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Mellitus has been sig ge 2 should b 1 Yes 2 No 3 Probably 4 1 No 3 Probably 4 1 No 1 Completed Peripheral Jascular Disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate ha autopsy performed? Non-Healing Foot uncer 1 ☐ Yes 2 ☑ No 1 Yes 2 10 No funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA | Other: 4 | Invaring Home 5 | Residence 6 | Other (Specify) 1 ☐ Yes 2 ₺ No ၉ After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 PNatural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation after death Director: / I in by the f 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel of within 24 hours af To the Funeral D completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) > Harin & Bobrt, M.D. D0058676 March 12, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 25 Main street, Suite 200, Reisterstown MD 21136 M.D. Karen L. Babitt 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Belgan B. Registrar MAR 1 8 2004

Jan Medo 04-1824 AKG **Physician**

Funeral

Director

or than "natural", or itema 23a or 28a-f ahow the Medical Examinar must be notified at

and Mental !

permit. Pages 1 and 2
Depertment of Health at
Importent: If Item 27 is.
any injury or other frame

Physician /Medical

Examiner

and

signed by the a

been sig

has page 2

certificate

After

the

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hours after death.

within 24 hours at To the Funeral D completely filled is

death certificate be executed attending physicien and for use as the burial-tran

The law requires that

or Attanding Physician:

the

Box 68760,

o

Records,

Division of Vital

with the Maryland

deeth

within 72 hours after

8

Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 [For State Registrar Certificate of Death 3. Time of Death 2. Date of Death Day 2004 1. Decedent's Name (First, Middle, Last) March 13, 4:21 A M Medo /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner HOward Ellicot City Route 100 east of Long Gate Parkway If Under 1 Year If Under 24 Hrs. Birthplece (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number Days 1**X**XM 2□ F Slovakia 1962 23, May 213-04-4709 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 Yes X No Columbia, Md. 21045 Howard MD Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21045 5620 Waterloo Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black White etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Marned Specify: white 1 ☐ Yes 2 No Specify: Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Construction CO. self-employed 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Helena Kuruczova Jan Medo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9428 Ridgeview Drive, Columbia, Md. 21046 Anna Medo/former wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 3/17/2004 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Laurel, MD. Balto./Wash.Crematory 22. Name and Address of Facility Witzke Funeral Homes, Inc. 21. Signature of Funeral Service L .8 5555 Twin Knolls Road, Columbia, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) INTURIES MULTIPLE Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 3 DEctopic pregnancy Year Month Day in the past 12 months?
1 Yes 2 No 5 Other (specify) 4☐Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

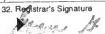
1,⊠Yes 2□ No 18 Yes 2 □ No 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence Denther (Specify) At Scene Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1XXes 2 No 28d. Describe how injury occurred 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death CPERATOR OF MOTORCYCLE 5 Pending investigation 1 Natural 1 Yes 2 No IN COLLISION 4:18 A 2 Accident 3/13/04 INVOUVED 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide ROAD EBRT 100 & LONG-WAY GATE PARKUAY, HO 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Tell Certifying my stolent. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2 Checkedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier March 13, 2004 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201

State Registrar 31. Date filed (Month, Day, Year) MAR 1 8 2004

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RUBIO



MD

			1 - For State Registrar	State of	of Maryla	ind / Depa	artment of F rtificate of	lealth ai Death		giene 2	004	08645
I	Physic	ian	Decedent's Name (First, Middle						2. Date of Da Month	ath Day	Year	3. Time of Death
	/Medi		Beatrice Mon						March	15	2004	6:45P M
	Examir	ner	4a. Facility Name (If not institution 5630 Ringwood				4b. City, Town, o		Death		ity of Death	
	Funeral		5. Social Security Number	6. Sex	it H	s. last birthday)	Haleth			h	timore	
	Director		214-44-7824	1 ☐ M 2 🖺 F	59	Yrs.	Months Days	Hours	Min. (Month, Da Feb. 24	y, Year)	Mary	lace (State or Foreign try) 1 and
	pu >		Usual Residence of Decedent 10a. State 10b. County			31 T			1100 2	192515		
	death with the Maryland ms 23a or 28a-f ehow rmast be notified at	ō	Maryland 10b. County	Baltimor		City, Town of Lo Halet					10	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
	28a-f	Director	10e. Street and Number	Dartimor		патес	10f. Zip Code			10- 01	(144)	
	3a or	0	5630 Ringwood	Drive Uni	+ H		212	27		10g. Citizen of		try ?
	death ms 2	Funeral	11. Marital Status	12. Was Dec	edent Ever in	U.S. 13.			n? (Specify Yes or No- Puerto Rican, etc.)	U . S	· A ·	an Indian,
٥	after or Ite		1 ☐ Never Married 2 Marr	ied 1 ☐ Yes If Yes, Gi	2 X No		fYes, specify Cuba 1 □ Yes 2 X XNo		Puerto Rican, etc.)		ack, White, e	etc.
2-003p	ural',	d by	3 ☐ Widowed 4 ☐ Divorced	Year or D	ates:		TO THE ZALINO	Specify:		Speci	wh:	ite
ņ	n 72 • nat	ompleted	15. Decedent (Specify only highes	's Education it grade completed)		(Give	dent's Usual Occupa kind of work done of DO NOT use retired	during most o	of working	16b. Kind of E	Business/Ind	lustry
7 7	l withi	dwo	Elementary/Secondary (0-12)	College (1-4or 5+)	<i>III</i> 6.	Conciere	•		Hot	1 م	
	Hyg other	C	17. Father's Name (First, Middle,	Last)					s Name (First, Middle,			
yiand	uld bu Menta Irked Itic ev	To B	Norman Philli	ps				Pea	arl Moran			
Mar	2 sho and 1 Is ma	ľ	19a. Informant's Name/Relationsh			19b. Mailir	ng Address (Street a	and Number	or Rural Route Numbe	r, City or Town	n, State, Zip	Code)
≥ ′2	and ealth m 27 her tr		Grover Monroe	(Husband				Drive	Unit H Ha	lethor	pe, MD	21227
20	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at ance.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 Removal from	State		natory or other plac		Date	20c. Location	- City or Tov	wn, State
Dallimor	rtmen rtant:		`4 □Donation 5 □ Other (Sp		Ва		sh. Crem			Laurel		
0	Depa Impo any ir		21. Signature of Funeral Service I	Licensee		W:	Name and Address itzke Fun	s of Facility eral H	Home of Cat Lyenue Cato	onsvil	le, In	ıc.
,007	Physician peach certificate be executed the control of the center of the	dical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Oue to	(or as a conse	equence of):			of coff			
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.O. DO.	The law requires that the death certif ate has been signed by the attending page 2 should be detached for use a	Physiclan/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		oirth 2 ☐ Fet lant at time of	tal death 3	Ectopic pregnancy Other (specify)				ate of deliver onth C	y Day Year
, cp	w requires that been signed t should be det	by	Part II. Other significant conditio	ns contributing to di	eath but not re	sulting in the ur	derlying cause give	n in Part I.		bacco use con es 2□No	tribute to the	cause of death?
וועכר	The law requate has been bage 2 should	Completed			-				24a. Was a autops perform	ned/	prior to com death?	sy findings available pletion of cause of
2	Physician: The rithis certificate har al director, page	Bec	25. Was case referred to medical examiner?					26. Place of	Death (Check only og		12.165 2	.0140
	Physic this ce al dire	2	1 ☐ Yes 2 ☐ No	Hospital: 1 □ I	npatient 2	ER/Outpatient	3□ DOA Othe	r: 4 🗆 Nursii	ng Home 5 side	ence 6 Oth	ner (Specify)	
	70 M	Certification;	27. Manner eath 1 tural 5 Pending 2 Accident investig	ation	of Injury h, Day Year)	28b. Time of Injury	28c. Injury Work M 1 \(\triangle Y	at ? ′es 2 □ No	28d. Describe ho	ow injury occur	rred	
-	± 1 = 1		3 Suicide 6 Could n 4 Homicide determin	ned 286. Place	of Injury - At h	nome, farm, stre ify)	et, factory, office		28f. Location (St City or Town	reet and Numb n, State)	ber or Rural i	Route Number,
	Fo the Hospital vithin 24 hours a to the Funeral (completely filled	edical	29a. Certifier 1 ertifying (Check only one)	Examiner: On the bi	best of my kn asis of examin ner stated.	owledge, death ation and/or inv	occurred at the time estigation, in my op	e, date and p inion, death o	place, and due to the ca occurred at the time, di	ause(s) and ma ate and place,	anner as stat and due to t	ted. he cause(s)
	U Militaria	2	29b. Signature and title of certifier	nd ste	ma	5	29c. License	-	4	9d. Date signe Uavd	4	
	9		Idward S	no completed caus	4	795	Print) Ayu	ahai	of board	61	ch Va	121061
	Sta		31. Date filed (Month, Day, Year)	10.4 €32. R	egistrar's Sign	ature						

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygien 👂 🛭 🗓 🗓 08646 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 03/14/2004 Year **Physician** 2:40 A M Augusta Martin /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Genesis Eldercare Severna Park | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | North | Days | Hours | Min. | 0 8/29/1907 Birthplace (State or Foreign Country)
 ATD 6. Sex 7. Age (In yrs. last birthday, 5. Social Security Number **Funeral** 1 ☐ M 2 🗹 F MD 96 217-07-9446 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ral', or Itama 23a or 28a-f show Examiner must be notified at 1 □Yes 2 No Pasadena Anne Arundel Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21122 Funeral 203 Glen Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🌠 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🗹 No Battimore, Maryland 21215-0036 "natural", or Specify: \$ 3 Widowed 4 □ Divorced White Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) traumatic event, IL + Ma Elementary/Secondary (0-12) College (1-4or 5+) other than Own Home Home Maker 10 18. Mother's Name (First, Middle, Maiden Sumame, 17. Father's Name (First, Middle, Last) Be is marked Margaret Rauh Andrew Ritter ೭ permit. Pages 1 and 2 shoul Department of Health and Milmportant; if item 27 is marl any injury or other traumations. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1630 Grandview Rd., Pasadena, MD 21122 Francis W. Wills/Grandson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 03/17/04 Crownsville, MD Vet Cemetery ¹ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility G.J.Gonce Funeral Home, PA 169 Riviera Dr., Pasadena, MD 21122 23a. Part1. Enter the dilease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician umoma disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Par Accident e br o vascu Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the attending physician and ned for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 menths?
1 Yes 2 No 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) 4☐Pregnant at time of death detached 9 Unknown 9 Unknown ል 23e. Did tobacco use contribute to the cause of death? signed Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 Unknown 1 ☐ Yes 2 □ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe certificate 1 Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ N6 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To this 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 Natural
2 Accident 5 Pendina 1 ☐ Yes 2 ☐ No М investigation Director: 6 Could not be determined 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c_License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ruy Millersvillo, 8601 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 1 8 2004 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygie2004Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician Thomas J. Marshall 13 2004 7:30 P.M March /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore N/A Harbor Hospital Center 6. Sex 1 M 2 ☐ F If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min 83 214 03 1119 Yrs. June 4, 1920 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location or items 23a or 28e-f show an intermed at 1 ☐ Yes 2X No Baltimore Anne Arundel Directo Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21225 U.S. 804 Old Riverside Road Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 X Yes 2 □ No If Yes, Give V Year or Dates: 1 Never Married 2 Married Specify: White WW II 1 ☐ Yes 2 No Completed by 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 16b. Kind of Business/Industry Maryland Ship Building Elementary/Secondary (0-12) College (1-4or 5+) Burning & Welding Department & Drydock 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) es 1 and 2 should be fit of Health and Mental H I itam 27 Is marked oth Be William Marshall Theresa Poturalski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2
Department of Health a
Importent: If itam 27 is
any injury or other tra Lori Chearney / Daughter 804 Old Riverside Road Baltimore, Maryland 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 3/17/2004 ` 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery Baltimore, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 romerou 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical by tructive Alyways Disease Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner anding physician and use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No ţō 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 Z No 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; 1 ☑Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after deat To tha Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) à 4 | Homicide filled in t Le Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

filed within 72 hours after death with the Maryland

netural

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed

or Attanding Physician:

To the Hospital

this

death.

Division of Vital Records, P.O. Box 68760,

31. Date filed (Month, Day, Year)

3400

32: Registrar's Signature

Evalman Avenue

Ba / hmox Maryland

www

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kameh Jabapalhi

State of Maryland / Department of Health and Mental Hygien [] [] [- State RegistrarAMEND ITEM #30 PER DVR G829 3/18/04/CErtificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 22:31 P Thomas R. McLaughlin, Jr. March 10. 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Good Samaritan Hospital Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 ☐ F 83 Pennsylvania Director 212-14**-**2362 October | Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 la marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, the Medical Example or most be notified at once. 1Y Yes 2 No Director Mary land N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code 1601 E. Belvedere Avenue 21239 USA Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Armed Polces? 1 Mayes 2 MowWII If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify White Specify 2 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Baltimore Gas & Electric Stationary Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Thomas R. McLaughlin, Sr. Laura Elizabeth Lynch 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mr. Thomas R. McLaughlin, III/Son 5 Old Spring Court Cockeysville Maryland 21030 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Mem. Gardens 3/15/04 Timonium Maryland 21. Signature of Funeral Service Licensee Christina L. Hilton

22. Name and Address of Facility
Leonard J. Ruck, Inc.
5305 Harford Road Baltimore Maryland 21214 Approximate Interval Between 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. nset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Ruaton /Medical Due to (qr as a consequence of que hou **Examiner** Anoxi a if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner be executed and burial-tran Te to (or as a consequence of): ed by the attending physician detached for use as the buria Division of Vital Records, P.O. Box 68760 Physiclan/Medical law requires that the death certificate IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Day Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 2 page 2 should be 4 Junknown 3 Probably 1 ☐ Yes 2 ☐ No Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 2/**D**No 2 DNO 1 Yes 1 ☐ Yes Hospital or Attending Physician: Be (25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 1 ☐ Yes 2 No 1 🗆 Inpatient P 3 DOA After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; 5 Pending investigation 1) Natural 1 ☐ Yes 2 ☐ No death. 2 Accident after death Director: 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral D The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 29c. License number 0 puraer 30 66 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SIREESH K. TRIPURANENI GOOD SAMARITAN HOSPITAL BALTIMORE, MD

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year)

MAR 1 8 2004

32. Degistrar's Signature

DHMH 17 Rev 1/2001

State Registrar

MARGARITA KOR 31. Date filed (Month, Day, Year) MAR 18

Monte



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

O.C.M.E.

March 14, 2004

111 Penn Street, Baltimore, Maryland 21201

M

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 24 2 2

			For State Registrar	State of M	iaryland / Dep <i>Ce</i>	artment of F rtificate of I	ieaith and i Death	nentai myę F	leg. No.	04 08650						
	Physici		Decedent's Name (First, Middle Dorothy	, Last) Ma	O N	Totacomo		2. Date of Dea Month	L4, Day 2004	3. Time of Death 01:37 P.M						
	/Medic Examin		4a. Facility Name (If not institution			4b. City, Town, or	Location of Death		4c. County	of Death						
	Exami	eı	6817 Beacon Pla			Capita	al Height	s	Princ	ce George's						
	Funeral Director		5. Social Security Number 244-70-2036	6. Sex 7. A	ge (In yrs. last birthday, 57 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 5-5-4	(, Year)	Birthplace (State or Foreign Country) N . C .						
	yland		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits						
	Mar.	tor	Md. Princ	e George's	Cap	oitAL Heig	ht			X□Yes 2□No						
	h the	lre	10e. Street and Number			10f. Zip Code			10g. Citizen of W	Vhat Country?						
	th wil	alD	626 Larchmmont	Ave.		2074	13		USA							
36	be filed within 72 hours after death with the Maryland ital Hygiene. id other than "natural", or items 23a or 28a-f show avent, the Medical Enartinal the indiffied at	by Funeral Director	11. Maritat Status 1 Never Married 2 Marr	12. Was Deceden Armed Forces ied 1 Yes 2 If Yes, Give Year or Dates:	t Ever in U.S. 13. ? No	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☐ No	ispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race Blac Specify	e - American Indian, ck, White, etc.						
21215-0036	ural	d b	3 ☐ Widowed 4 ☐ Divorced 15. Decedent			dent's Usual Occup	ation		16h Kind of Bu	BLack usiness/Industry						
5	nat nat	Completed	(Specify only highes	st grade completed)	(Give	kind of work done of DO NOT use retired	during most of world)	king	100. Killa di Ba	isiness/industry						
12	withis ane. than	Ę.	Elementary/Secondary (0-12)	College (1-4or	5+)	Care Ass			Hoal:	th Care						
2	filed Hygie Sther ent, II		12th grade 17. Father's Name (First, Middle,	Last)	Home	care Abi	18. Mother's Nam	e (First, Middle,								
Maryland	2 should be filed withir and Mental Hygiene. Is marked other than aumatic avent, the Ma	Be			cMillian											
Ž	s 1 and 2 should I I Health and Meni Itsm 27 is marked other fraumatic	2	Archie 19a. Informant's Name/Relationsi			ing Address (Street	Eunic			Cker						
Z	d 2 sl h an 7 is r traur		Regina McMillia			eann Ct.,				27572						
	Health tsm 27 other tr		20a. Method of Disposition	II NIEC		osition (Name of matory or other place		Date Date		City or Town, State						
ğ			1 Surial 2 Cremation	3 Removal from State	9) .			2.04								
₫.	t. Partmer		*4 Donation 5 Dother (S		Rockfish			-		sville, N.C.						
Baltimore,	permit. Pages 1 a Department of Hes Importent: If itsm eny injury or othe		21. Signature of Funeral Service	yo Wan	2. Name and Addre	I. East	1101 E	more, Morth	Ave.							
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cause only one cause on each	ed the death. Do not en line.	ter the mode of dyin	ng, such as cardiac	or respiratory ar	rest,	Approximate toterval Between						
ê.	Physician		mmediate Cause (Final disease or condition _ a. LIVER CIRRUSIS													
	/Medical		resulting in death)		s a consequence of):											
	Examiner		Sequentially list conditions.	b												
	0 =	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	s a consequence of):											
	ocute nd trans	am	Cause (Disease or injury that initiated events resulting in death) Last	с.												
O O	ificate be executed g physician and as the burial-transit		resulting in death) cast	Due to (or a	s a consequence of):											
68760,	ate be nysic he be	edical		d												
_	T 0 6		tF FEMALE:				-									
Вох	The law requires that the death certificate has been signed by the attending tage 2 should be detached for use as	by Physician/M	23b. Was decedent pregnant	23c. If yes, outcom		□Ectopic pregnancy	,		23d. Date	te of delivery nth Day Year						
	ne dea the att	SCI	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐ Pregnant a	at time of death 5	Other (specify)			14101	in Day Tour						
P.0	that the ded by the detached	h	9 ⊠Unknown													
	res tha	by	Part II. Other significant condition	ons contributing to death	but not resulting in the	underlying cause giv	en in Part I.			ribute to the cause of death?						
ב	w requir been si should I							1 L Y	es 2 No	3 Probably 4 Unknown						
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æ	The lav	E						perfor	med? d	death? I ⊠Yes 2 □ No						
ital		0	25. Was case referred to medical				26. Place of Dea									
of Vital Records,	N S D	To B	examiner? 1X Yes _ 2 ☐ No	Hospitat: 1 ☐ Inpat	tient 2 ER/Outpatie	nt 3 DOA Oth	er: 4 Nursing He	ome 5 Resid	ence 6 Nothe	er (Specify) At scene						
0	g Ph er th		27. Manner of Death	28a. Date of In	jury 28b. Time o	of 28c. Injur	y at	28d. Describe h	ow injury occurr	ed						
Ö	Attending r death. sctor: After by the fune	atlo	1 ØNaturat 5 ☐ Pendin 2 ☐ Accident investi	y .	ay roury injury		Yes 2 □No									
Division	or Attending I after death. Director: After in by the funer	iţi	3 ☐ Suicide 6 ☐ Could determ	ined 286. Place of II	njury - At home, farm, si	reet, factory, office		281. Location (S City or Ton	treet and Number	er or Rural Route Number,						
Ö	al or A s after il Direction by	Certification:		building, 6	atc."(Specify)			July Of 10W	, 0.010/							
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely tilled in by the funeral	edical C		ng Physician: To the bes Examiner: On the basis and manners	of examination and/or in											
	o the	Me	29b. Signature and title of certifie			29c. Licens	e number		29d. Date signed	d (Month, Day, Year)						
	⊢ 3 ⊢ ŏ		· Quant	2		0	.C.M.E.	1	March 15	5, 2004						
	Ţ		30. Name and address of person	.0.1010 .	death (Item 23a) (Type	Print) 111 Pen	n Street,	Baltim	ore, Mar	ryland 21201						
	Sta	ate	31. Date liled Month Day, Year	44	trar's Signature											
67	Ponict			-	1.5											

State of Maryland / Department of Health and Mental Hygien 08651 Certificate of Death Reg. No. 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 255 N 03 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Nestover OrrCh Inst If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 1111 Ke Sex 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Months Days 1∭ M 2□ F 43 Yrs. Dec 5, Virginia Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show ust be notified at 1 Yes 2 No **Funeral Director** MD Somerset Westover 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ö 30420 Revells Neck Road 21890 USA 230 unk 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ੴNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 5 1 ☐ Yes 2 No Specify: Specify: black the Medical Expr <u>ک</u> 3 ☐ Widowed 4 ☐ Divorced 'netural' Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unk 16b. Kind of Business/Industry unk 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Jerry Osborne Sr Letitia Taylor Pages 1 and 2 should ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Lepartment of Health an Importent: If Item 27 is m. any injury or other: Once. Letitia Osborne/mother 1135 Poplar Grove Street Baltimore, MD 21216 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☑ Other (Specify) in State in state State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 21. Signature of by an Sprice dicensee wade, mon Baltimore, MD 23a. Pant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Central Nevone Se der **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed physician and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Dav 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No o 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, NONE 1 Yes 2 No 3 Probably 4 Vnknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 Yes 25 No of Vital Attending Physicien: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 Yes 2 □ No this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: Division 1° Natural 5 Pending 1 TYes 2 No investigation Director: / 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours are To the Funeral Dir 15 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier DO050826 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 30420 Nevell'S Neck RD Westora 21890 8C1 RAZPAIC ENIDIA 31. Date filed (Month, Day, Year) 32. Angistrar's Signature State MAR 1 8 2004 Registrar

State of Maryland / Department of Health and Mental Hygienes 004 08652 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 6:03pm 15, March 2004 Anna Lorraine Peddicord /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Ferbrook Manor 0denton If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 ☐ M 25 F 216-28-6674 84 2, Maryland Director Nov. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 🔀 No Director Maryland Ellicott City Howard 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or Itame 23a 21043 5012 Waterloo Road United States Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 ☐ Never Mamed 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No M Specify Specify: If Yes, Give Year or Dates: White 3 Widowed 4 □ Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) rthan Elementary/Secondary (0-12) College (1-4or 5+) 12 High School Secretary permit. Peges 1 and 2 should be filed Department of Health and Mental Hygis Important: If item 27 is marked other any injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Euston Rutherford Seward Julia Ruth Albright 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Lorraine Tabler - daughter 8316 Grove Road, Ellicott City, Maryland 21043 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 XOther (Specify) Fintantament Loudon Park Cemetery 3/19/2004 Baltimore, Maryland 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Signature of Funeral Service License ODCe. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or combications that caused the death, shock, or heart failure. List only the sause on Jich Inc. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician eal /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed burial-transit and Due to (or as a consequence of): Box 68760, the attending physicien Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy nse n 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 2 | Fetal death ŏ Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a P.O. I 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, \$ 2 13No 3 Probably 4 Unknown 1 ☐ Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 D No 24a. Was an autopsy performe has page 2 certificate 1 Yes 24 No Division of Vital Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify, Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Mannerof Death within 24 hours after death. To the Funerel Director: After 5 Pending Injury 1 Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide ö To the Hospitel Medical 29a. Certifier 1 L certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29h Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) (9 address of pers n/who completed cause of ath/Item 23a) (Type, Print) 30. Name

DHMH 17 Rev 1/2001

State

Registrar

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1 8 2004

31. Date filed (Month, Day, Year)

MD . Registrar's Signature

			For State	State of Marylan				lealth and Death	Mental Hy	/gien Reg. N	200	11.	08653
			Registrar 1. Decedent's Name (First, Middle, Last)						2. Date of D	eath		, ••	3. Time of Death
Н	Physici		MILDRED				PI	ERCE	Month	ch o	16 20	04	4:16 AM
	/Medic Examin		4a. Facility Name (If not institution, give s	street and number)		4b. Cit	, Town, or	Location of Dea	th	4	c. County of [Deeth	
			The Johns HOPK	ns Hospital		Bal	timo	re Cit	7		NA.	1	
	Funeral		5. Social Security Number 6. Sex	M SERE	last birthday Yrs.) If Und Month:	or 1 Year Days	If Under 24 Hf Hours Mir	. (Month, D	ay, Yea	r) 9.	Count	ace (State or Foreign ry)
	Director		213-20-6736 Usual Residence of Decedent	83					5-27-	20		Md.	
	yland		10a. State 10b. County	10c. Cit	ty, Town or L	ocation.						10	d. Inside City Limits
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	or 28	Director	10e. Street and Number		01.5	10f. Z	ip Code			10g. C	itizen of Wha	t Count	ry?
	ath w		1400 E. Madison				2120		0	-	USA 14. Race - /	A	a tadios
36	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or items 23a or 28s-1 show other than "natural", or items 23a or 28s-1 show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3√□ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes ②☐ No If Yes, Give Year or Dates:	.5. 13.	If Yes, sp		ispanic Origin? (in, Mexican, Pue Specify:	Specify Yes or N rto Rican, etc.)	0-	Black, V		tc.
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yla	should be and Mental marked o	၉	Harry	Gree				Marie			olt		2 - 1-1
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	s 1 and 2 of Health a ttem 27 is		20a. Method of Disposition	20b. F	Place of Disp	osition (N	ame of		Date		Location - City		
o	ages int of t: if it y or o	10	1 ☐ Burial 2 ☐ Cremation 3 ☐ R '4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	cemetery, cre				22 04	0	i i i i i i i i i i i i i i i i i i i	277	- Ma
Baltimore,	permit. Pages 1 Department of H Important: If Ite any njury or ot		21. Signature of Funeral Service License		rrisor			et : 3−∠ ss of Facility	22-04 Ralt		ings M e, Md.		1202
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	Physician		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition	ne cause on each line.		nter the m	ode of dyin	g, such as cardia	ac or respiratory	arrest,			Approximate Interval Between Onset and Death
	/Medical		resulting in death)	Due to (or as a consec									week
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687	ficate be executed physician and is the burial-transit	dical		1									
Box (death certifical attending phase as t	√/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregn.							23d. Date of	deliver	у
.O. Bo		Physician/Me	in the past 12 months? 1 □ Yes 2 ⊠No 9 □ Unknown	1 □ Live birth 2 □ Feta 4 □ Pregnant at time of c 9 □ Unknown		∐Ectopic ☐ Other (pregnancy specify)				Month	1	Day Year
٥.	requires that the een signed by th hould be detache		Part II. Other significant conditions cor	ntributing to death but not res	sulting in the	underlying	cause givi	en in Part I.	23e. Did	tobacco	use contribu	te to the	cause of death?
ds,	sign d be	d by					9		10	Yes	2 No 3	Proba	ibly 4 ∑ Unknown
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Re	9 C B	шс							per	opsy formed? 2 2 4	deat	to com	pletion of cause of
ta	ician: Th certificate ector, pag	a	25. Was case referred to medical					26, Place of De	1 ☐ Yes eath (Check only	-	0 10	103 /	
Ţ	S 0 0	To B	examiner? 1 ☐ Yes 2 🔀 No	fospital: 1 × npatient 2	EP/Outpatie	ent 3 🗆 1	Oth	er: 4 Nursing	Home 5 Res	sidence	6 Other (Specify	
n of			27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time Injury	of	28c. Injun Wor	y at k?	28d. Describe	how inj	ury occurred		
Sio	Attending r death. ector: After by the fune	catio	2 Accident investigation			М		Yes 2 No					
Division	spital or Atten ours after deat neral Director: filled in by the	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	iome, farm, s fy)	treet, fact	ory, office		28f. Location City or To	(Street a own, Sta	and Number o te)	r Rural	Route Number,
	Hospital 24 hours a Funeral (29a. Certifier 1 X Certifying Phys	sician: To the best of my kno	awledge des	th occurre	nd at the tin	ne, date and nia	a and due to the	2 621150/	c) and manne	r ac etc	ted
	To the Hosp within 24 ho To the Function Completely f	edical		ner: On the basis of examina and manner stated.	ation and/or i	nvestigati	on, in my o	pinion, death oc	curred at the time	, date a	nd place, and	due to	the cause(s)
	o the	Me	29b. Signature and title of certifier			2	9c. Licens	e number		29d. D	ate signed (N	fonth, D	ay, Year)
	- > - 0		Doot A. Ber	huse mo			RES.	- 000		mA	rc 14	16	, 2004
	\ ^		30. Name and address of person who co	ompleted cause of death (Item	m 23a) (Type	Print)							
	U		SLOTT BERKGESITZ JOY	this HOPKINS Ito	SPITM	- 600	Nora	H woufest	NEET T	BALTI	more, n	AN	VAND ZIZ8
ř	Sta		31. Date filed (MoMPR, Yar 8 20	04 32. Registrar's Sign	ature	hans	-						

04-1825 **AKG** Maryland 28a-f show the ō WIT or itema 23a death Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Dal PArk State of Maryland / Department of Health and Mental Hygiene 2004 08654 For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** Dal Park March 13. 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) Examiner Route 100 east of Long Gate Parkway Ellicot City Howard If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 6. Sex 1⊞M 2□ F 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Months 20 11/18/1983 Korea Director 218-53-4311 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Ellicott City Md Howard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 7778 Blueberry Hill Lane 21043 Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Importent: if Item 271s marked other then "naturel", or Item any injury or other traumatic event, the Medical English 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 🖁 No Specify Asian Specify: If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Cotlege (1-4or 5+) College Student Graphic Design 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Unknown Jin Beom Kim ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7778 Blueberry Hill Lane, Jin Beom Kim/mother Ellicott City, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2X Cremation 3 Removal from State 18/2004 Laurel, Md. Balto/Wash.Crematory ` 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Witzke Funeral Homes, Inc. 21. Sign 5555 Twin Knolls Rd, Columbia, 21045 23a. Part1. Enter the disease, or complications, or heart failure. List only one Approximate Interval Between Onset and Death ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ause on each line. Immediate Cause (Final TW WELS **Physician** MUUNIG resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, isating to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical Examiner the attending physicien and ned for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þe 2 No 3 Probably 4 Unknown 1 🗌 Yes 1990 24b. Were autopsy findings available prior to completion of cause of 24a. Was an prior to co death page 2 2 No 1 Yes 2 🗆 No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: ¥XYes 2□ No 4 Nursing Home 5 Residence 6 Nother (Specify) At SCENE Certification: To completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27 Manner of Death 28d. Describe how injury occurred 4:18 Y W Division 1 Natural 5 Pending PASSWHER IN MOTOREYUS STRUMEGUANO 1 Yes 2 No -13-04 investigation within 24 hours after death. To the Funerel Director: A 2 Accident 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) building, etc. (Specify) 4 | Homicide EBRIDO E O LONGO ECKWY HOWSOND HO To the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) mill mulyme O.C.M.E March 13, 2004 MID fr 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DROW MANY NOTO
31. Date filed (Month, Day, Year) 111 Penn Street, Baltimore, Maryland 21201 32. Registrar's Signature State MAR 1 8 2004

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2001

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2 <u>20</u> 20 10 10 10 10 10 10 10 10 10 10 10 10 10	Funeral Director		5. Social Security Number 6. Security Number 10 11 Usual Residence of Decedent	7. Age (In yr	85 Yrs.	Months			8. Date of Birth (Month, Day, APRIL 10	Year) C	thplece (State or Foreign ountry) ARYLAND
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and	be de la	To Be	17. Father's Name (First, Middle, Last) CLARENCE	B	RIGH	TEIL		JOR A	,	Maiden Surname)	AiG
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	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune	edical C		ysician: To the best of my k niner: On the basis of exam and manner stated.							
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		1 - State of Maryland / Department of Health and N Certificate of Death	lental Hy	giene200	08656
Physic	cian	1. Decedent's Name (First, Middle, Last)	2. Date of De Month March	Day 16, 200	3. Time of Death
/Med	lical	Theodore Reith 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	FIALCII	4c. County of Di	
Exam	iner	Greater Baltimore Medical Center Towson		Baltim	
Funera Directo		$ \begin{array}{c ccccccccccccccccccccccccccccccccccc$	8. Date of Birt (Month, Da AUG 19	9. E 9, 1929 No	Birthplace (State or Foreign Country) BW York
/land		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
e Man	ctor	Maryland Baltimore Timonium			1 ☐ Yes 2 ☐ No
vith th	Funeral Director	10e. Street and Number 10f. Zip Code		10g. Citizen of What	Country?
leath v	eral	312 Overlook Drive 21093 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp	ecify Yes or No	USA 14. Race - Ar	merican Indian,
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: if item 27 is marked other than "netural", or items 23e or 28e-f show any injury or other traumatic event, its Medical Expresses any miles any one of the contract of the medical Expresses and the contract of the medical Expresses.	by Fun	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No Specify: 1 Yes 2 No Specify:	Rican, etc.)	Black, W Specify:	hite, etc. White
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id be fental rked o	To Be	Theodore Reith Frances	Coles		
and N		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Run		er, City or Town, State	, Zip Code)
and			Cimonium Date	*	
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nit. Paramer autment ortant injury	à	^4 □ Donation ² 5 □ Other (Specify) Metro Crematory Inc. 3-18 21. Signature of Funeral Service Licensee 22. Name and Address of Facility.		Baltimore	
Deparmine Permi		Cremation Society Thomas Gregory 299 Frederick Ros	of MD, ad Bai	Inc.	21228
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.			Approximate Interval Between
Physiciar		Immediate Cause (Final disease or condition resulting in death) Intracerebral hemorrhage			Onset and Death 1 week
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To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: Alter this certificate ha completely filled in by the funeral director, page	edical Ce	29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner: On the basis of examination and/or investigation, in my opinion, death occur and manner stated.	and due to the ored at the time, or	cause(s) and manner date and place, and d	as stated. ue to the cause(s)
To the within To the	Med	29b. Signature and title of ceatitier 29c. License number		29d. Date signed (Mo	nth, Day, Year)
. , , , ,		D52278		March 17,	2004
10		30. Name and iddress of person who completed cause of death (Item 23a) (Type, Print)		-	EVV.
10		Amiel Bethel, MD 6569 N. Charles Street #403 Baltimor 31. Date filed (Month, Day, Year) 32. Segistrar's Signature	e, MD 2	1204	
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		•	For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of rtificate of	Health a f Death	nd Mental H	ygiene [04	08657
	8		Decedent's Name (First, Middle, Las)				2, Date of I		Year	3. Time of Death
	Physici /Medic		Charles	W.	Sc	hueler		March	16, 2004	4	11:25 AM
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	Funeral Director		215-24-3110	x XM 2□F	e (In yrs. last birthday, 74 Yrs.	If Under 1 Yea Months Day		Min. 8. Date of E Month, January	Birth Day, Year) 24,1930	9. Birthp Cour MD	place (State or Foreign ntry)
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				1	Od. Inside City Limits
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	28a-	rec	10e. Street and Number			10f. Žip Code)		10g. Citizen of	f What Cour	ntry?
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36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23e or 28e-f show or other traumatic event, it a Medical Examinat multiplied at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 XI If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cu		in? (Specify Yes or I Puerto Rican, etc.)	No- 14. Ra BI Spec	ace - Amendack, White,	etc.
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<u>Ş</u>	should be ind Mental s marked o umatic eve	ဥ	Charles L. Schuel		19h Mail	ing Address (Stre		r or Rural Route Nun	ther City or Tow	n State Zir	Codel
<u>N</u>	id 2 si th an 27 is t		Geraldine Schuele					ive,Dunda]			, 6000,
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Ë	Page nent o int: If		1 ☐ Burial 2 【XCremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specify		Bayview			2004	Baltim	ore Ci	ity,MD
Balti	permit. Pages 1 and 2 Department of Health a Important: If item 27 is eny injury or other tra QRGs.		21. Signature of Funeral Service Licen	C. Con	weller	7110 Sol	lers Po	al Home Of oint Road,	Dundal	k,P.A. k,MD.	21222
	Physician /Medical		23a. Part1. Enter the disease of comp shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a	a consequence of):	ter the mode of d	ying, such as o	cardiac or respiratory	arrest,		Approximate Interval Between Onset and Death
	cate be executed by physician and mile burial-transit	dical Examiner	Sequentially list conditions, france, landing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с.	a consequence of):						
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	h		30. Name and address of person who		death (Item 23a) (Type	, Print)					
	J		EDDIE NAKHUDA, M 31. Date filed (Month, Day, Year)		DULANEY VA	ALLEY RO	AD TIM	ONIUM, MD	21093		
	Sta Regist		31. Date filed (Month), Day, 16a)	bene	a B	Sporks	/				

DHMH 17 Rev 1/2001

MARCH 16,

SCHUELER, CHARLES

08658 State of Maryland / Department of Health and Mental Hygiene? [] [] [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 15, Day 2004 Physician Pauline B. Smith 11:15 p M /Medical 4a. Facility Name (If not institution, give street and number) 4h City Town or Location of Death 4c. County of Death **Examiner** Joseph Richey Hospice Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 □ F 242-32-0266 80 July 26, 1923 North Carolina Director Usual Basidence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County r then "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 □ Yes 2 □ No XX Director Prince George's College Park 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 9014 Rhode Island Avenue 20740 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, 11 Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White Completed by 3 XVidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "ne any injury or other traumatic event, the Mental once. Elementary/Secondary (0-12) College (1-4or 5+) Grade 11 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Charles Biddix Edna Head 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Brenda Joyce Cushwa/daughter 12 Almanac Court Burtonsville, Md. Baltimore. 20a. Method of Disposition
1 ☐ Burial 2 ☐ Fernation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State West Arundel Crematory 3/17/2004 Odenton, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Donaldson Funeral Home, P.A. 313 Talbott Avenue Laurel, 21. Signature of Funeral Service Licensee ∠ M00770 Laurel, Maryland 20707 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cancer Physician UNG months disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) ☐ Yes 2√2 No 9☐ Unknown 9 Unknown Š signed I Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 Yes 2 No 200 No of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) H 55 / CE Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 ☐ Yes 2 🗷 No 3 DOA P 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After Hospital or Attending 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident **Director:** 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours after To the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 03.16.200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. EVIA 17 #305 ALTIMORE MO ? M ANANDA KIL 32. Registrar's Signature 31. Date filed (Month, Day, Year) Registrar

			I.u	Please	Type or Pr			delible ink artment of l			-		_	08659
		-	For State Registrar					rtificate of				Reg. No		00005
	Physicia		Decedent's Name	e (First, Middle, La	st)						Date of Dea	Da	ıy Year	3. Time of Death
	/Medic		Walter	Hughes	Stepp						March	15		4:42 a M
	Examin		4a. Fecility Name (I	If not institution, giv	e street and numbe	er)		4b. City, Town,	or Location	of Death			. County of Dee	
			Laurel	Regional				Laure.					rince G	
P	Funeral Director		5. Social Security N 226-24-		Sex IDM 2□F 7.	Age (In yrs. last i	Yrs.	If Under 1 Year Months Days		Min.	Date of Birt (Month, Da an 16	y, Year,		thplece (State or Foreign ountry) cginia
	P .	-	Usual Residence of	f Decedent 10b, County		10c. City, To	um or la	nation						10d. Inside City Limits
	Maryla e-f ehov	tor	MD	Prince (George's	Laur		Cation						1 D Yes 2 □ No
	a or 28	i Dire	10e. Street and Nu	mber trose Ave	enile			10f. Zip Code 20707					tizen of What Co	ountry?
	ha 2:	era	11. Marital Status		T	nt Ever in U.S.	13.	Was Decedent of	Hispanic Or	igin? (Specif	y Yes or No		14. Race - Ame	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 ie marked other than "natural; or Itema 23a or 28a-f ehow other traumatic event, the Medical Examiner must be nailified at	by Funeral Director		ied 2∑Xiarried 4 □ Divorced	Armed Force 1 Xes 2 If Yes, Give Year or Date	nt Everin 0.5. 1943− □No 1963		If Yes, specify Cut 1 ☐ Yes 2 🛛 🔏			an, etc.)		Black, White Specify: White White White Specify:	e, etc. nite
9	2 hou	Completed	/0	15. Decedent's E	ducation	16	Sa. Dece	dent's Usual Occu	ipation	et of working		16b. F	(ind of Business	Industry
218	within 7 ene. than "r	pie	Elementary/Seco	ondary (0-12)	Coltege (1-4	or 5+)	life.	kind of work done DO NOT use retire	ed)	St OF WORKING				
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Maryland	12 should be filed within " h and Mental Hygiene. 7 le marked other than " traumatic event, the Med	Be	17. Father's Name	(First, Middle, Last)					er's Name <i>(F</i>			n Sumame)	
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a	2 sh and le m			ame/Relationship (ng Address (Stree			_	-		
3,	and lealth m 27	1 3		ine Step	o / spo			Montrose sition (Name of	Avenu	le Lat Date	irel,		yLand 2 .ocation - City or	20707
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: if Ifem 27 le any injury or other trai			•	Removal from Sta	ite ceme	tery, crei	matory or other pla can's Cer		3/19/2			eltenhar	
Balt	Departi Departi Importi any inj once.		21. Signature of Fu	uneral Service Lice	nsee	M00770		Name and Addr Donaldsor 313 Talbo					Maryland	20707
	Physician /Medical Examiner purial-Itansit	l Examiner	shock, or heal immediate Cause disease or condition resulting in death) Sequentially list colif any, leading to incause. Enter Undicause (Disease of that initiated event resulting in death)	art failure. List only (Final on onditions, mmediate ertying r injury s	b. Choli Due to (or	h line.	ce of): LS ce of): :hmia							Interval Between Onset and Death
68760	ate hys	lica			d			<u> </u>						
.O. Box 6	attending for use as	Physician/Medical	IF FEMALE: 23b. Was deceder in the past 12 1 □ Yes 2 9 □ Unknown	? months? □ No		n 2 □ Fetal déa tat time of death		Ectopic pregnand Other (specify)					23d. Date of de Month	livery Day Year
٥.	res that the digned by the be detached	Ph	Part II. Other signi	ficant conditions	contributing to deat	h but not resulting	g in the u	nderlying cause g	iven in Part	l.	23e. Did to	obacco	use contribute to	the cause of death?
ds.	requires that een signed b nould be deta	d by	Hyperte	nsion							101	Yes 2	XXNo 3∏P	robably 4 🗀 Unknown
Records,	e law has b	Completed	Leukocy	tosis							24a. Was autop perfo	an osy ormod? 2 10 No	24b. Were all prior to death?	utopsy findings available completion of cause of
Vital	ician: Th certificate ector, pag	BeC	25. Was case refe	rred to medical					26 Plac	e of Death (C			1 103	2010
5		To B	examiner? 1 ☐ Yes 2 🗙	No	Hospital: 1XXnp	atient 2 ER/	Outpatie	nt 3 DOA	thon				6 ☐Other (Spe	cifv)
Division of	ther ine		27. Manner of Dea 1 X Matural 2 ☐ Accident	th 5 Pending investigation	28a. Date of I (Month,		o. Time o Injury	f 28c. Inju		280			iry occurred	
Divis	after des Director	Certification:	3 Suicide 4 Homicide	6 Could not to determined	289. Place of	Injury - At home, , etc. (Specify)	farm, st	reet, factory, office	9	28f	Location (S City or Tox	Street a wn, Stat	nd Number or R e)	ural Route Number,
-	To the Hospitel or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifier (Check only one)		hysician: To the be miner: On the basi and manner	s of examination								
	Vithin Fo the	Me	29b. Signature and	d titled certifier				29c. Licer	nse number		- 13	29d. Da	ate signed (Mont	h, Day, Year)
	- x1		•	Bru	lemo.	Alten	sug		2580			1	March 15	2004
	10		P.S. Au	ress of person who ijla, M.D	completed cause of 5638 A	of death (Item 23: nnapolis	a) (Type, Roa	ad Blade	ensbur	g, Mar	ryland	20	0710	

State Registrar DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)
MAR 1 8 2004

1200 1-16-25

STEPPWINTER

32. Registrar's Signature

08660 State of Maryland / Department of Health and Mental Hygien [] [] [] Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** March 2004 11:05A.™ Aurelio Spessato /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Johns Hopkins Bayview Care Ctr. Baltimore n/a If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) July18, 1914 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** 1.8 M 2 ☐ F 217-07-7057 89 Italy Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County r than "natural", or itema 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2 PNo Director Md. Baltimore Dundalk 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7126 Crestshire Road 21222 USA Funerai death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2∑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo Specify: Baltimore, Maryland 21215-0036 White Specify: ξ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+) Beth Steel permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier important: If item 27 is marked other th any injury or other traumatic avent, If any once. Inspector 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Francis Spessato Van Jelia Maria 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Wilma M. Spessato 7126 Crestshire Rd. Baltimore, Md. 21222 (wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State Sacred Hrt.of Mary 3/17/04 Baltimore, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Kaczorowski Funeral Home, PA 21. Signature of Funeral Service Licensee 23a. Part1. Enter the discusse, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1201 Dundalk Ave. Baltimore, Md. 21222 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Renal Failure 4 years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal dea

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 Other (specify) 1 □Yes 2 □ No detached 9 Unknown 9 Unknown þ signed be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Atherosclerotic Coronary Artery Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Diabetes Mellitus 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed? Stroke certificate 1 Yes 2 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) director Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 After this funeral dir 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 TYes 2 No 2 Accident after death Director: / 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide on 24 hours.
The Funeral Directory filled in 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 D 0059189 March 14, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5505 Hopkins Bayview Circle Balto., Md. 21224 Jeremy S. Barron, M.D.

State Registrar 31. Date filed (Month, Day, Year) **MAR 1 8 2004**

32. Registrar's Signature

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State of Maryland / Department of Health and Mental Hygien 2004 08661 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2004 MARCH 12, Da **Physician** 8:00 p M ELIZABETH FRANCES /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Record Street Home Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month) Days Hours Min. Dec 17, 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 ☐ M 2 💢 F 85 Director 214-12-2501 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County or 28a-f show other traumatic event, the Medical Examiner must be notified at MD Frederick Frederick 1 ☐ Yes 2√ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 115 Record Street or Itams 23a 21701 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 10 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: λ Specify: white 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: if item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) teller banking 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Francis Leo Smith Edna Elizabeth Eader 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paul E. Smith/brother 510 Apple Avenue Frederick, MD 21701 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot once. 1 Burial 2 Cremation 3 Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Sonature of Euneral Sun ce Licensee Ron + 11 S Wade 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street nen Baltimore, MD 21201 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed transit the attending physicien and Due to (or as a consequence of): use as the burial-Division of Vital Records, P.O. Box 68760 Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy 1 I ive birth jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be 3 Probably 4 DUnknown Completed has been 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No this certificate 1□ Yes 2 No To the Hospital or Attanding Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Vursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 3 DOA 28c. Injury at Work? 27. Manper of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Aiter 1 Natural 5 Pending Injury death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Chack only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier Mus 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 360

State Registrar

MAR 18 2004

31. Date filed (Month, Day, Year)



Corrine	Schillir	ngs
04-1872		
AKG	1-	For State Registrar

Corinne Jeannine Schillings

State of Maryland / Department of Health and M Certificate of Death			08662
Middle, Last)	2. Date of Death	.,	3. Time of Death
0 1 7 1 0 3 1441	Month Day	Year	

Day

2004

March 15.

3:20

	1. Decedent's Name (First, Middl	e, Last)
Physician /Medical		ori
Examiner	A CONTRACTOR OF THE STATE OF TH	n, give s
	Inner Harbor n	ear
Funeral	5. Social Security Number	6. Sex

Baltimore, Maryland 21215-0036

 $\stackrel{\cancel{ iny N}}{\nearrow}$ Division of Vital Records, P.O. Box 68760,

Examin	er	4a. Fecility Name (In	not institution,	, give street and no	ımbər)		4b. City,	Town, o	r Location	of Death		4c. (County of De	ath
				ear Fort				timo				l	N/A	
Funeral Director		5. Social Security N 323 66 6		6. Sex 1 □ M 2 🖾 F	7. Age (In yrs	i last birthda Yrs.	Months	Days	If Under Hours	Min	Date of Bi (Month, D uly I	rth ay, Year) 197	7 9. B	irthplace (State or Foreign Country) [111inois
pu		Usual Residence of			10= 6	City, Town or	Landing							10d. tnside City Limits
Aaryla f show	ō	Virginia	10b. County Arli	ngton		Arling								1 ☐ Yes 2 ☑ No
the t	Director	10e. Street and Nur						Code			T	10g. Citiz	en of What (Country?
3a or		1500 N.	12th	Street Ap	ot. #13			2220	09			τ	J.S.	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Items 23a or 28a-f show any injury or other traumatic svent, the Medical Examiner must be muffied at once.	by Funerai	11. Marital Status 1 ☑ Never Marri 3 ☐ Widowed	ed 2□ Marri	12. Was Dec	cedent Ever in orces? 2 🙀 No ive	U.S. 1	3. Was Dece If Yes, spe		lispanic Ori an, Mexicar Specify:	igin? (Specif n, Puerto Ric	y Yes or No an, etc.)		4. Race - An Black, Wh Specify: W.	
2 hour			15. Decedent	's Education		16a. De	cedent's Usu	al Occup	ation			16b. Kin	d of Busines	s/Industry
within 7 iene. then *n	Completed	(Spec Elementary/Seco		College 4 Vea	(1-4or 5+)	life	bmaste	se retired	<i>auring</i> mos d)	st of working		The	e Cato	Institute
Hygother other	0	17. Father's Name	First, Middle, I						18. Mothe	er's Name (F	irst, Middle			
Aenta Aenta rked tic sv	O B		Denny	Shilling	js					Karen	Mari	e Kre	ek	
nd 2 shorath and h		19a. Informant's Na Denny S		nip <i>(Type, Print)</i> ngs / Fat	her		ailing Address			er or Rural R Ho				. Zip Code) S 60430
Pages 1 a lent of Hez nt: If item ry or othe		20a. Method of Disp 1 X Burial 2 (1 4 □ Donation	☐ Cremation	3 □Removal from	State	cemetery, c	position (Nairematory or c	other plac		3/20/2				r Town, State
permit. Departm Importa any inju		21. Signature of Fu	neral Service I	Licensee	unh:		22. Name ar 4001. R	nd Addre	ss of Facili	y Gonc ghway				ce, P.A. ryland 21225
		23au art1. Enter the	ne disease, or	complications that	caused the de	ath. Do not	enter the mod	de of dyir	ng, such as	cardiac or re			<u> </u>	Approximate Interval Between
Physician		tmmediate Cause (Finat		wnim	Cours	licat	le cl	by	hypo	thes	nic	2	Onset and Death
/Medical Examiner		resulting in death)		Due to	(or as a cons	no esneup			J		,			
A	Examiner	Sequentially list confidence in any, leading to imcause. Enter Under Cause (Disease or that initiated events resulting in death) I	rlying injury	С	(or as a conse									
ificate b g physic as the b	edica			d										
that the death certificate be executed be by the attending physician and of detached for use as the burral-transit	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 1 Yes 25 9 Unknown	months?	1 Live	utcome of pregi birth 2 Pe mant at time of nown	tel death	3 □Ectopic p 5 □ Other (sp		<i>'</i>			23	3d. Date of de Month	elivery Day Year
	by Ph	Part II. Other signif	icant conditio	ns contributing to	death but not re	sulting in the	underlying o	ause giv	en in Part I	l.		_	_	to the cause of death?
w requires been sign should be	eted							· · · · · ·			10	Yes 2	LNo 3□F	Probably 4 Unknown
sicien: The law requires certificate has been sign irector, page 2 should be	Comple											psy ormed?	prior to death?	autopsy findings available completion of cause of
iffic.	0	25. Was case refer	red to medical						26. Place	of Death (C	124 Yes	2 No No	1/X(Ye	3 2 10
Physicien: r this certifica ral director, p	To B	examiner?	No	Hospital: 1	Inpatient 2	☐ ER/Outpat	ient 3 DC	Oth Oth	er: 4 🗆 Nu	ursing Home	5 🗌 Resi	dence 6	⊠Other (Sp.	ecity) At scene
nding Ph th.: After th e funeral		27. Manner of Death 1 □ Natural 2 ★ Accident	h 5 □ Pending investig	9	of Injury oth, Day Year) (0-04	28b. Time Injur 4:50	_ 🗇	28c. Injun Wor 1 🗆		No Pa	Describe	how injury	occurred D	eceased ter
To the Hospital or Attending Physicia within 24 hours after death. To the Funeral Director: After this cent completely filled in by the funeral director.	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could n determi	289. Plac	e of Injury - At ling, etc. (Spec	home, farm,	street, factor	y, office	_		Location (Street and wn, State)	DUMA	Rural Route Number,
e Hospit 24 hour e Funera letely fille	edical (29a. Certifier (Check only one)	1 Certifyin 2 Medical I	g Physician: To th Examiner: On the and ma	e best of my kr	nowledge, de	ath occurred	a the tin	ne, date an pinion, dea	nd place, and ath occurred a	due to the at the time,	cause(s) a date and p	ind manner a	is stated.
To th within To th сопр	₩ W	29b. Signature and	title of certifier	1	111		29	c. Licens	e number			29d. Date	signed (Mor	nth, Day, Year)
~/		M	CV	m	VV		(O.C.1	И.Е.			March	16, 2	2004
18		30. Name and addr	ess of person	who completed cau	ise of death (Ite	em 23a) (Typ		Peni	n Str	eet, B	altim	ore,	Maryla	and 21201
Sta		31. Date filed (Man	AR Year	2004 32	Registrar's Sign	nature	frank!	,						

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year SHIFLET 2.50 AM March 2004 OAN 17

10f. Zip Code

Disable

21225

1 ☐ Yes 2X No Specify:

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

CENTER

10c. City, Town or Location

Baltimore

7. Age (In yrs. last birthday)

61

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 X No If Yes, Give Year or Dates:

College (1-4or 5+)

4b. City, Town, or Location of Death

If Under 1 Year If Under 24 Hrs.

BALTIMORE

Hours

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

4c. County of Death

10g. Citizen of What Country?

14. Race - American Indian.

Specify: White

16b. Kind of Business/Industry

U.S.

N/A

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

6 days

Day

2 No

29d. Date signed (Month, Day, Year)

03-17-2004

1X Yes 2 No

Maryland

N/A

1942

8. Date of Birth (Month, Day, 1) Dec. 30,

18. Mother's Name (First, Middle, Maiden Sumame)

Ethel McCall

Dec.

Physician /Medical **Examiner**

Funeral

Director

1 - State Registrar

10a. State

Maryland

11. Marital Status

10e. Street and Number

Director

Funeral

þ

Completed

Be

HARBOR

217 40 2396

Usual Residence of Decedent

5. Social Security Number

4a. Fecility Name (If not institution, give street and number)

10b. County

1321 Church Street

1 Never Married 2 Married

3 X Widowed 4 ☐ Divorced

Elementary/Secondary (0-12)

17. Father's Name (First, Middle, Last)

10th

N/A

15. Decedent's Education (Specify only highest grade completed)

Howard Selig

HOSPITAL

1 ☐ M 2 💢 F

1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Madical Examinar must be notified at

Health item 27 i permit. Pages 1
Department of H
Important: If Itel
any injury or oth

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

death certificate be executed use as the burial-transit the attending physician and Division of Vital Records, P.O. Box 68760, for been signed by page 2 should be certificate has Attending Physician: After this funeral death. the within 24 hours after deat To the Funeral Director: filled in by 0 Hospital

Examiner Physician/Medical Completed by Be Certification: To Medical completely

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Son Dundalk, Maryland 21222 Joseph Shiflett / 81 Del-Rio Road 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 3/19/2004 Bayview Crematory Baltimore, Maryland * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Deep 22 Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Septicaemia disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Breast -1 KrYes 2 □ No 3 ☐ Probably 4 ☐ Unknown ancer 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Minpatient 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA 28b. Time of Injury 28a. Date of Injury (Month, Day Yeer) 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 A Natural 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Chack only and manner stated

State Registrar

1

31. Date filed (Month, Day, Year) MAR 1 8 2004

29b. Signature and title of



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

In Tern

3001 SitHanover Street Baltimore, MD. 21225

29c. License number

RES

001

the

Barbara Thompson RI

4-0 PD	1615			Se Type or Pr State of N	Maryland / Dei	artmo	ent of H	lealth and	All Copies Mental Hy	giene	egible.	08664	
			1 - State Unpend ITem#2 Registrar 1. Decedent's Name (First, Middle	Ja,27,20a-1,F	er Mc,6029, <i>g</i>	stuite.	ate of	Death		Reg. No.	Year	3. Time of Death	
	Physici /Medi		Barbara Th			_,			March	3 , 2	004	1110 P M	
10	Examir		4a. Facility Name (If not institution, Bon Secours Hos		r)		ity, Town, o altimo	r Location of Dea DIC	th	4c. C	County of Deeth		
	Funeral Director		5. Social Security Numberunk	6. Sex 1 ☐ M 2 🕅 F	Age (In yrs. last birthda 42 Yrs.	y) If Un Mont	der 1 Year hs Days	If Under 24 Hrs Hours Min		th <i>y, Year)</i> • 196	Cou	nplace (State or Foreign intry) 11and	
,	pu 🗼		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location						10d. Inside City Limits	
	e Maryla 8a-f shor	Director	MD			Balti						1√2Yes 2□No	
	th with the		10e. Street and Number 308 S. Monroe S	treet		10f.	Zip Code 212	23		10g. Citize	en of What Cou USA	untry?	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 23s-1 show other traumatic event, the Wedical Examples could be notified at	by Funeral	11. Marital Status 1 Never Married 2 Marri 3 Widowed 4 Divorced	12. Was Deceder Armed Forces ad 1 Tyes 2 Fif Yes, Give Year or Dates	s? [] No	If Yes, s	cedent of H specify Cuba s 21 No	lispanic Origin? (: an, Mexican, Pue Specify:	Specify Yes or No rto Rican, etc.)		14. Race - American Indian, Black, White, etc. Specify: white		
Š	2 hou	ted	15. Decedent	s Education	16a. Dec	edent's L	Isual Occup	ation	orking unk	16b. Kind	d of Business/fi	ndustry	
21215-0036	vithin 7 ne. hen "n	Completed	(Specify only highes Elementary/Secondary (0-12) unk	College (1-40	life	DO NO	T use retired	during most of wo d)	orking Gille			un.	
Maryland 2	i be filed withintal Hygiene.	Be	17. Father's Name (First, Middle, I	unk ast)			unk		me (First, Middle,		iumame)		
Ž	2 should be and Mental Is marked o	T ₀	19a. Informant's Name/Relationsh	ip (Type, Print)	19b. Ma	iling Addr	ess (Street		lural Route Number		Town, State, Zi	ip Code)	
	and 2 sealth ar n 27 is ner trau		Susan Darpino/o						Baltimor				
Baltimore,	Pages 1 and 3 ant of Health nt: If Item 27 y or other tr		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☒ Other (Sp		20b. Place of Dis cemetery, cr	position (Name of		Date		ation - City or T		
Baltii	permit. Pages Department of Inportant: If Ite any injury or of 2000.		21. Sign tu a 1 Euneral Prvice L		ss of Facility Omy Boar MD 212	d 655 W.	Balt	imore	Street				
藤	Physician /Medical		23a. Pert 1. Enter the disease, or shock or heart failure. List Immediate Cause (Final disease or condition resulting in death)	Methadon a.	ed the death. Do not e line. e Intoxicatio	nter the n			c or respiratory a	rrest,		Approximate Interval Between Onset and Death	
200	Examiner			Due to (or a	is a consequence of):								
100	t insit	Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	is a consequence of:								
,09	e be executed sician and burial-transit	<u>a</u>	that initiated events resulting in death) Last	Due to (or a	is a consequence of):								
687	g phy as the	edic											
.O. Box	at the death certificate by by the attending physic lached for use as the b	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☑ Unknown		2 Fetal death 3	□Ectopi □ Other	c pregnancy (specify)	•		23	d. Date of deliv Month	rery Day Year	
S, D	as this	by	Part II. Other significant condition	ns contributing to death	but not resulting in the	underlyin	g cause giv	en in Part I.		obacco use		the cause of death?	
Record	The law require ate has been sip page 2 should b	ompieted								rmed?	prior to co death?	opsy findings available ompletion of cause of	
Vital		O O	25. Was case referred to medical					OR Place of Do	ath (Check only o	2 No	1 DY es	2 ∐ No	
>	Physician: this certific ral director,	0	examiner? 1∑Yes 2☐No	Hospital: 1 Inpa	tient 2 ER/Outpati	ent 3/X/	DOA Oth	ar:	dome 5 ☐ Resid		Other (Speci	fv)	
) of		i.	27. Manner of Death	28a. Date of In	jury 28b. Time		28c. Injun Wor		28d. Describe I			.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
Ö	Attanding I r death. actor: After by the funer	atio	1 Natural 5 Pending	ation $3/3/6$:45p		Yes 2 XNo	urknown				
Division	in Diffe	Certification:	3 Suicide 6 Could n 4 Homicide determi	and 200. Flace of I	njury - At home, farm, : etc. <i>(Specify)</i>	tory, office		28f. Location (S City or Tow 308 S. Mo	vn, State)		al Route Number,		
	e Hospital 24 hours a e Funaral I	edical	29a. Certifier 1 Certifying (Check only 21 Medical I	Physicien: To the best	st of my knowledge, de- of examination and/or	ath occurr	ed at the tin	ne, date and plac pinion, death occ	e, and due to the	cause(s) ar	nd manner as s	stated.	
	To the Hos within 24 h To the Fun completely	Medi	one)	and manner	belete		29c. License			- 20			
}	Vit COr	_	29b. Signature and title of certifier	honia-	Holler 1	no	O.C.1				signed (Month, $\pm h$ 4 , 20		
			30. Name and address of person	no completed cause of			enn S	treet, B	altimore	, Mar	yland 2	21201	
	Sta Regist		31. Date filed (Month, Day, Year)		strar's Signature	and)							

Registrar DHMH 17 Rev 1/2001 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene? 0.0.1

	6.	•	- State Amend Item 17 per Registrar	er FH,G829,03/18/	04dhb Cer	tificate of I	Death	Reg	. No.	08665	
	Physicia		1. Decedent's Name (First, Middle, Las	t)	-0.0	000.1		2. Date of Death Month	Day Year	3. Time of Death 6:35A.M.	
Verber	/Medic	al	4a. Facility Name (If not institution, give	street and number)	TAUB		r Location of Deatl	Werth	14 2004 4c. County of Dea		
	Examin	er	NORTHWEST HOSPIT				LSTOWN		BALTIMO	RE	
2.5	Funeral Director		5. Social Security Number 098-12-1327 6. S		1920 9. Bir	thplace (State or Foreign ountry)					
	land		Usual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Limits	
	Mary B-f sh	tor	MD BAL	TIMORE	BALTIM	ORE				1 ☐ Yes 2 ☐ No	
	ith the	Director	10e. Street and Number			10f. Zip Code		10g	. Citizen of What C		
	s 23a	erai	3524 BARTON OAKS 11. Marital Status	ROAD 12. Was Decedent Ever in	U.S. 13 V	Was Decedent of H	21208	pecify Yes or No-	14. Race - Am	U.S.A.	
Maryland 21215-0036	be filed within 72 hours after death with the Maryland tal Hyglene d other than "natural", or items 23a or 28a-f show event, it to M. creal Examinal rount to notified at	by Funeral	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No If Yes, Gwe Year or Dates:			Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 ☑ No	an, Mexican, Puert Specify:	o Rican, etc.)	Black, Whi		
5-0	72 hc "natur	Completed	15. Decedent's Ed (Specify only highest gra		16a. Deced	dent's Usual Occup kind of work done DO NOT use retired	ation during most of wor	rking	6b. Kind of Business	/Industry	
121	withir iene. then	dwo	Elementary/Secondary (0-12)	College (1-4or 5+) 4		EMAKER	2)		OWN HOME		
פַ	be filed tal Hyg d other event,	BeC	17. Father's Name (First, Middle, Last)	<u>_</u>	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		18. Mother's Nar	ne (First, Middle, Ma	iden Sumame)		
ylaı		70 E	JOSEPH Joseph		BLO		ELIZA			JESSEL	
Mar	s 1 and 2 should f Health and Mer Item 27 Is marke other traumatic		DAVID TAUBMAN			,		. LAUREL,			
	s 1 an of Heal Item 2 other		20a. Method of Disposition	20b.	Place of Dispo	sition (Name of natory or other place		STATE OF THE PARTY	c. Location - City or	·	
imo	0 0		1 ☐ Burial 2 🖾 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification of the content of the conte	TOWSON	<u> </u>						
Baltimore,	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licer	Cutter			STERSTOWN		IKESVILLE	., INC. , MD 21208	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the de- one cause on each line.	ath. Do not ent	er the mode of dyin	ng, such as cardiad	or respiratory arres	t,	Approximate Interval Between Onset and Death	
X	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	α.	WNI	B					
	Examiner		Due to (or as a consequence of):								
	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Ener Underlying Cause (Disease or injury	Due to (or as a conse	equence of):						
	icate be executed physicien and the burial-transit	Examiner	that initiated events resulting in death) Last	c	equence of);						
68760,	e be e /sicien e buriz	edicai E		_ d							
	rtificat ng phy s as th	Medi	IF FEMALE:	-							
P.O. Box	The law requires that the death certificate be executed to the as been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	y		23d. Date of de Month	23d. Date of delivery Month Day Year				
	res that igned by be deta	by Ph									
ords	w require been sig shoutd b		<u> </u>					1 🗌 Yes	2 □ No 3 □ P	robably 4 Unknown	
of Vital Records,		Completed						24a. Was an autopsy performe	prior to death?	utopsy findings available completion of cause of	
Zit.	0 0 0 E	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpatient 2	☐ ER/Outpatier	nt 3 DOA Oth	er.	ath <i>(Check only one)</i> Home 5 🗆 Residen		ocifu)	
o of	g Physier this	n: To	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o		ry at	28d. Describe how		scriy)	
sior	Attending For death. ector; Atter by the tuner	catio	1 Natural 5 ☐ Pending 2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not b	n		M 1 🗆	Yes 2 □No				
Division	atter d atter d Direct d in by	Certification:	4 Homicide determined	28e. Place of Injury - At building, etc. (Spe	home, farm, str cify)	reet, factory, office		City or Town,	et and Number or R State)	lurai Houte Number,	
	To the Hospital or Attendii within 24 hours after death. To the Funeral Director; A completely filled in by the tu	Medical C	29a. Certifier 1 Certifying Pt (Check only one) 2 Medical Exam	nysician: To the best of my k niner: On the basis of exami and manner stated.	nowledge, deat nation and/or in	h occurred at the til vestigation, in my o	me, date and place opinion, death occi	e, and due to the cau urred at the time, dat	se(s) and manner a e and place, and du	s stated. e to the cause(s)	
	To th Withir To th comp	M	29b. Signature and title of certifier			29c. Licens	se number	290	d. Date signed (Mon	th, Day, Year)	
	1		Azortan	111		D4.	3471	3	arela	14 2004	
	15		30. Name and address person who	completed cause of death (It	em 23a) (Type,	Print)	Burne	his	21061	1	
State Registrar MAR 1 8 2004 State Registrar											

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 08666 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** March 16,2004 8:15 a^M Julia M. Thorpe /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Manor Care Towson Baltimore 8. Date of Birth (Month, Dey, Year)
Dec. 12,1917 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Hours 1 ☐ M 2 🖺 F Maryland 215-10-8218 86 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County Itam 27 is marked other than "natural", or Itams 23a or 28a-f ahow other traumatic avant, the Mudical Examinar must be notified at Towson 1 ☐ Yes 2 No Funeral Director Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 509 East Joppa Road 21286 U.S.A. 14. Race - American Indian. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or iten any injury or other fraumatic avant, the Medical Exerciti 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: white 1 ☐ Yes 2X No Specify: Be Completed by 3

Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Crown Cork & Seal Machine operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Chester Machowik Antonina Kacmarek 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hugh Gourlay - attorney 16 Whips Lane Baltimore, Maryland 21236 20c. Location · City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State Moreland Cemetery 3/17/2004 Baltimore, Maryland * 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Charles S. Zeiler & Son, Inc. 21. Signature of Funeral Service Licenses 6224 Eastern Avenue Baltimore, Maryland 21224 Part1. Enter he isease, or complications that caused the death. shock, or hearfailure. List only one cause on each line. Approximate Interval Between Onset and Death mode of dying, such as cardiac or respiratory arrest. Do not enter t Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to ler ass **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a o Physician/Medical Examiner use as the burial-transi that initiated events resulting in death) Last signed by the attending physicien and Due to (or as a densequence IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year be detached for 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown should peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? this certificate has autopsy 1 ☐ Yes 20 N 1 Yes 20 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Diractor: After this certifica 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Mursing Home 5 Residence 6 Other (Specify) 1 Yes 25 No Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred injury 1 Natural 5 ☐ Pending 1 Tes 2 No investigation 2 Accident filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Sogcify) determined 4 Momicide 29a. Certifier 1 Certifying Phy sician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

ner: On the lasis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Exam ner: On. 29b. Signature and title of c pr 30. Name and address of person who completed cau ath (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

18

death with the Maryland

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00 1; 08667 State AMEND ITEM #26 PER PHY G829 3/18/04 JBertificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Yeer **Physician** Filomena B. Vecchio March 11,2004 11:25 A^M /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Ellicott City
Under 1 Year | If Under 24 Hrs.
onths | Days | Hours | Min. <u>3216 Cornell</u> Lane Howard 8. Date of Birth (Month, Day, Yeer) Birthplace (Stete or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 1 □ M 2 🗶 F Yrs 052-20-0978 77 30, Director May 1926 New York Usual Residence of Decedent r 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1 ☐ Yes 2X No Director N.Y. **Onondaga** Syracuse the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with r than "natural", or Items 23a or the Medical Examinar qual be 13208 USA Funeral 337 Hickok Ave 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 Yes 2 No white Yes Give Specify: Specify: þ If Yes, Give Year or Dates: 3X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own Home 11 other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) i. Pages 1 and 2 should be file timent of Health and Mental Hy tant: If Item 27 is marked oth ijury or other traumatic eveni Be Mary Marra Thomas Rinaldi ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3216 Cornell Lane, Ellicott City, Md. 21042 Amelia McAllister Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete permit. Pages Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Kemoval from State Syracuse, N.Y. * 4 ☐ Donation 5 ☐ Other (Specify) Assumption Cem. 3/15/2004 22. Name and Address of Facility Witzke Funeral Homes, Inc. 21. Signature of Funeral Service Licenses 15555 Twin Knolls Rd.Columbia, MD.21045 23a. Part1. Enter the disease, or shock, or heart failure. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Sacrai **Physician** MODIC 1 year resulting in death) /Medical Due to (or as a consequence of): Examiner Dementic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner ng physician and as the burial-transit death certificate be executed Markinsons 5 years resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Por Month Day Year 5 Other (specify) ed by the a detached f 1 ☐ Yes 2 ☐ No The law requires that the 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ostcoporosis 3 ☐ Probably 4 ☐ Unknown 1 TYes 2 No Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has certificate has autopsy performe 2 No 1 Tyes 1 Yes 2 No or Attending Physician: rector. 26. Place of Death (Check only one)
Other: 4 Nursing Home Statesidence 6XXX ther (Specify)

DAIGHTER's 25. Was case referred to medical examiner? Be Hospital: 1 Inpatient 2 EP/Outpatient 2 1 ☐ Yes 2 🖽 0 3 DOA HOME 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending Injury 1 ☐ Yes 2 ☐ No death. investigation after death Director: the 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 - Homicide within 24 hours at To the Funeral D completely filled it 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the i 29b. Sign 29c. License number 29d. Date signed (Month, Day, Year) ature and title

State Registrar

Maryland 21215-0036

Box 68760

Records.

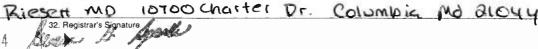
Vital

Division of

31. Date filed (Month, Day, Year) 1 8 2004

Vandal

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



058747

march 11, 2004

J			1 - For State Registrar	State of Marylan			nt of Health and te of Death	d Mental H	-	Z 11 11 to	08668	
	Physici /Medi		Decedent's Name (First, Middle, Last Left)	n. WhiTe	711			2. Date of Month	D:		3. Time of Death	
	Examir Funeral Director		4a. Facility Name (Ithot institution, give Johns Hopkins I 5. Social Security Number 6. Social Security Number	Iospital	ast birthday) Yrs.	Bâ	Town, or Location of D Itimore 1 Year If Under 24 I Days Hours N	eath drs. 8. Date of (Month,	Birth Day, Year	c. County of Death A 9. Birthp Cour	place (State or Foreign	
		ctor	Usual Residence of Decedent 10a. State 10b. County Md	· · · · · · · · · · · · · · · · · · ·				MARE	14 27	200 n	0d. Inside City Limits 1	
ore, Maryland 21215-0036	72 hours after death with the Maryland naturel", or Items 23e or 28e-f ehow licel Examinar most be notified at	Funeral Director	10e. Street and Number 2 4 2 5 M 11. Marital Status	Adi SON 85 12. Was Decedent Ever in U.S Armed Forces?	2/20 Society Ever in U.S. 13. Was Decedent of Hispanic Origin? (Society) If Yes, specify Cuban, Mexican, Puert					itizen of What Cour 2, 5, - 14. Race - Americ Black, White,	an Indian,	
	d within 72 hours aft piene. r then "natural", or the Medical Exerti	Completed by F	Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Ed (Specify only highest gra	1 ☐ Yes 2 2 No If Yes, Give Year or Dates: ucation de completed) College (1-4or 5+)	16a. Deced	kind of wo	2 No Specify: al Occupation ink done during most of se retired)	working	16b. F	Specify: 13/1	,	
	be filed stal Hyg of othe event,	To Be Com	17. Father's Name (First, Middle, Last)	white I		No		Name (First, Midd	lle, Maidei	Non- n Sumame)	C	
	Pages 1 and 2 should lent of Health and Men nt: If Item 27 is marke iry or other traumatic		19a. Informant's me/Relationship (7) 20a. Method of Disposition 3 □ Cremation 3 □	20b. Pl.	ace of Dispos	sition (Na		Date 1	N /	Ocation - City or To	. MD 3140	
Baltimore,	permit. Pages Department of Important: If I eny injury or		21. Signature Fundral 5 Price Licen	Butt	KDW1 22	Name at	Mem. PM. 3 Address of Facility S. F. M. C. A.	Hon lest.	BA /T	round.	nd.	
ist.	Physician /Medical Examiner		23a. Part. Enter the disease, or companies, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	a. SHOKE /A Due to (or as a consequence)	JHALF ence of):	31 (116) 1110(ie or dying, such as care	IGRMAL	arrest,		Approximate Interval Between Onset and Death	
8760,	cate be executed physician and the burial-transit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequence of the consequence o								
.O. Box 6	death certifi e attending d for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnar 1□Live birth 2□Fetal 4□Pregnant at time of de 9□Unknown	death 3 🗌	Ectopic pr Other (sp	egnancy ectry)	23d. Date of delivery Month Day Yea				
۵.	The law requires that the tee bas been signed by the base been signed by the bage 2 should be detached.	by	Part II. Other significant conditions co	intributing to death but not resul						tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown		
Vital Records,		e Completed	25. Was case referred to medical				26 Place of F	per	opsy formed? 2/2 No	prior to com death?	osy findings available apletion of cause of	
Division of V	ding Ph h. After th funeral	Certification: To B	examiner? 1 X Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined		R/Outpatient 28b. Time of Injury 3:33 A ne, farm, stre	2 M	8c. Injury at Work? 1 Yes 2 No	Home 5 Res 28d. Describe V1 CT11	me 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred VLTIH OF HOVSE FIRE 28f. Location (Street and Number or Rural Route Number,			
Ω	To the Hospitel or Attene within 24 hours after death To the Funeral Director: completely filled in by the I	edical Cer	Duilding, etc. (Specify) RESIDENCE 291. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
)	To the within > To the compl	Me	29b. Signature and title of certifier	29c. License number O.C.M.E.			29d. Date signed (Month, Day, Year) March 15, 2004					
	Sta Registr		30. Name and address of person who can be seen and address of person who can be seen as a seen and address of person who can be seen as a seen as		-	111	Penn Stre	et, Balt	imore	e, Maryla	nd 21201	

State of Maryland / Department of Health and Mental Hygieney 08669 For State Registrat Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Rose Mary Weaver 4:58 P M March 16 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Knollwood Manor Millersville Anne Arundel | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | June 12, 1 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex **Funeral** Months 1 □ M 2 😾 F 215-22-6652 76 Director 1927 Maryland Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State or 28a-f show Examiner must be notified at 1 ☐ Yes 2X No Maryland Howard Hanover Direct 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 6331 Hanover Road 21076 United States death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "naturel", or 1 ☐ Yes 2√ No Specify: White 3√ Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) f Health and Mental Hygiene. item 27 is marked other than other traumatic event, it is M Own Home 8 Homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Samuel Brocato Concetta Papa 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane Ordakowski - Daughter 6335 Hanover Road Hanover, Maryland 21076 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Importent: If ite any injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
1 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Park 3/20/04 Glen Burnie, Maryland 21. Signature of Funeral Service Licensee Cary L. Kaufman Funeral Home At MMP., Inc. 7250 Washington Blvd. Elkridge, Maryland 21075 Hab Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** PNEUMON IA WEEKS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directo (or as a nonsequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): the attending physician a hed for use as the burial-Box 68760. Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) signed by the a Division of Vital Records, P.O. 1 ☐ Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 □Únknown 1 ☐ Yes 2 🗷 No should I Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? this certificate 1 Yes 2 No al director 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Cther: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 XNo 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation Director: / 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after of To the Funerel Direct completely filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation in my place death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 31136 V 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Horida Rd. Nottinghow, mo 21236 Wallace Drian (mi) 1000 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 1 8 2004 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 🤈 State
Ragistramend ITEM #10a-f PER FH G838 42/28/04 Heath 2. Date of Death 3. Time of Death Vear **Physician** Paul E. Weaver 8:30A^M March 14 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Gilchrist Hospice Center Towson Baltimore If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Nov. 27, 1929 Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F Yrs. 74 Alabama 266-36-2877 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show s 23a or 28a-f shor FL Maryland 1 Yes 2 No Director Howard Ellicott City OCALA 10e. Street and Number 9539 10f. Zip Code 10g. Citizen of What Country? 2902 21043 **3448**1 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status the Medical Examiner of 1 X Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 No Specify Specify: ۵ 3 ™ Widowed 4 □ Divorced White WW II Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Jeweler Jewe1ry other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any jury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Jacob Lee Weaver Frances Hamlett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Trish Shafer (Daughter) 1016 W. Joppa Road Towson, Maryland 21204 20b. Place of Disposition (Name of cometery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State 1 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest 3-19-2004 Owings Mills, Maryland 21. Signature of Funeral Service Lightses 22. Name and Address of Facility Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue Catonsville, Maryland 21228 Approximate Interval Betwee In August D. at 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760. Physiclan/Medical the use as 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 3 Ectopic pregnancy signed by the atte Month Day 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Unknown 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an cate has l autopsy performed 1□ Yes 🖋 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one Hospital: Other: 1 ☐ Yes No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence A Z Medical Certification; To 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident filled in by the I 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exampler: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and filte of certifier 29d. Date signed (Month, Day, Year) son who completed cause of death (Item 23a) (Type, Print) RODING4 31. Date filed (Many) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygieney 08672 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year **Physician** February 27, 2:06 P M Jerry Anderson 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring
| If Under 1 Year | If Under 24 Hrs. |
| Months | Days | Hours | Min. | Montgomery 6. Sex 1 ☑ M 2 ☐ F 8. Date of Birth (Month, Day, Year)
Dec. 16,1952 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 212-64-0500 51 Director Usual Residence of Decedent 10a. State 10b. Caunty 10c. City, Town or Location 10d. Inside City Limits "natural", or Items 23e or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Md. Montgomery Director Derwood 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 17505 Ira Court 20855 Funeral United States death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic avant. In a Magnus. Elementary/Secondary (0-12) College (1-4or 5+) 5+ Electrical Engineer Aeronautics 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Strother R. Anderson Sarah Isabelle McCracken 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Anderson (Wife) 17505 Ira Court Derwood, Md. 20855 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 29, 20c. Location - City or Town, State Feb. 1 Burial 2 Cremation 3 Removal from State Alexandria, Va. Metropolitan Crem. 4 ☐ Donation 5 ☐ Other (Specify) 2004 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DeVol Funeral Home uctis 2222 Wisconsin Ave. N.W. Washington D.C. 20007 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Respiratory Arrest /Medical Due to (or as a consequence of): Examiner Brain Edema Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and s the burial-transit the Hospitel or Attending Physician: The law requires thet the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) P.0. 0 signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23a. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has page 2 autopsy performed? 1 ☐ Yes director 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 Siq. 27. Manner of Death 28a. Date of Injury (Month, Day Year) Medical Certification: 28b. Time of 28c. injury at Work? Alter t 28d. Describe how injury occurred 1 XNatural 5 Pending death. 2 🗌 No investigation 1 Tyes unerel Director: / 2 Accident 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signatora and title of 29c. License number 29d. Date signed (Month, Day, Year) 000 person woo completed cause of death (Item 23a) (Type, Print) 30. Name and address Godfrey M.D. 1500 Forest Glen Rd. Silver Spring, Md. 20901 Dr.Catherine 31. Date filed (Month)

DHMH 17 Rev 1/2001

State

Registrar

32. Aegistrar's Signature

2004

			recese i	State of Marylar				Mental Hyg	iene	
			1 - For State Registrar	,		rtificate of		Re	_{19. No.} 2 0 0	4 08673
	Dhysisi		1. Decedent's Name (First, Middle, Last)	!				2. Date of Deat Month		3. Time of Death
	Physici /Medic		Helen Marie Eliz		son		1 1 15 1		y 28, 20	
	Examin	er	4a. Fecility Name (If not institution, give :				r Location of Death ISVILLE		4c. County of	
-	Funeral		Holy Cross Rehab 5. Social Security Number 6. Secu	7. Age (In yrs.		If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,	Montg	Birthplace (State or Foreign Country)
	Director		051-01-9876	M 280 F 91	Yrs.	Months Days	Hours Min.	May 13,	1912	New York
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation				10d. Inside City Limits
	Mary Fe eho	to	Maryland Prince G	eorge's I	aurel					1 ☐ Yes 2 反 No
	death with the Maryland ms 23e or 28e-f ehow rreust be notified at	Directo	10e. Street and Number			10f. Zip Code		11	0g. Citizen of Wha	al Country?
	s 23e	rai	16104 Kent Road		10	2070			USA	
	ter de	Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U Armed Forces? 1 □ Yes 2 ☑ No			lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	Black,	American Indian, White, etc.
5	172 hours after death with the Marylan "natural", or Nams 23e or 28e-f show ofical Examirer must be notified at	þ	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☒ No	Specify:		Specify:	White
ب	d within 72 ho giene. Ir then "netu	Completed	15. Decedent's Edu (Specify only highest grad		16a. Dece (Give	dent's Usual Occup kind of work done	ation during most of work d)	ing	16b. Kind of Busin	ness/Industry
7	withir ane. then	dwc	Elementary/Secondary (0-12)	College (1-4or 5+)		inting/Sa			Busine	ess
Maryland 21215-0036	othe	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, N		
<u>Jar</u>	should be nd Mental marked o	To E	Frank Burnett					Elizabet		
Jan	12 sho		19a. Informant's Name/Relationship (Ty Carol A. Foley/ I				and Number or Rur			ate, Zip Code)
(a)	1 and Heattl tem 27		20a. Method of Disposition				oad, Laur (Marcl		20c. Location - Cit	ty or Town, State
Baltimore,	ages ont of the state of the st		1 ☑ Burial 2 ☐ Cremation 3 ☐ P 4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State Ga	te of Ceme	esition (Name of matory or other place Heaven	9) Marci 20(1 Z,		Spring, MD
a	permit. Pages 1 and 2 should by Department of Heatils and Menta Importent: If Item 27 is marked any injury of other traumatic app.ce.		21. Signature Funeral Service Acens		Cene 2	2. Name and Addre	ss of Facility Collins			
m	89558		July S.	Sceres	5	<u>00 Univer</u>	sity Blv	1. W., S:	<u>ilver Sp</u>	<u>ring, MD 20901</u>
			23a. Part 7. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final	cations that caused the deal ne cause on each line.	th. Do not ent	ter the mode of dyin	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Congestive Due to (or as a consec		Failure				1 year
	Examiner		One and the Kenness division	Pneumonia	quotico ory.					2 weeks
360	P ==	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec						
	be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	Chronic Ob Due to (or as a consec		ive Pulmo	nary Dise	ase		5 years
760,		calE		1						La companya da la com
9	eath certificate attending phy for use as the		IS SELVALE.				A		2.12	
Вох	ath ce ttendi	ian/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregn. 1□Live birth 2 □ Feta	al death 3	Ectopic pregnancy	,		23d. Date of Month	of delivery Day Year
o o	The law requires that the death the has been signed by the atter bage 2 should be detached for u	Physician/Med	1 ☐ Yes 2 ☒ No 9 ☐ Unknown	4☐ Pregnant at time of o 9☐ Unknown	death 5	Other (specify)				
ر. ت	s that in the part is a deta	by Ph	Part II. Other significant conditions con	ntributing to death but not res	sulting in the u	nderlying cause giv	en in Part I.	23e. Did tob	acco use contribu	ite to the cause of death?
ğ	w requires been sign should be							1 □ Ye	s 2□No 3[☐ Probably 4 ∰Unknown
Records,	lawra nasbe B 2 sh	Completed						24a. Was ar autopsy	/ prio	re autopsy findings available if to completion of cause of
_									⊠ No 1 □	tn? Yes 2□ No
Vital	rsicial s certifi directo	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	lospital:	ER/Outpatier	nt 3 DOA Oth	0.5	h <i>(Check only one</i> me 5 ☐ Reside		(Spacific)
Division of	iding Phys th. : After this funeral di	J: T	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	-	y at	28d. Describe ho		epoony)
S	tendii Jeath. Tor: A the fu	catio	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □No	201 1 1 (0)		
Σ	or Attend after death Director: / Jin by the f	Certification;	4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	fy)	eet, factory, office		City or Town		or Rural Route Number,
	prite ours seral		29a. Certifier 1⊠ Certifying Phys	sician: To the best of my know	owledge, deat	h occurred at the tin	ne, date and place,	and due to the ca	use(s) and manne	er as stated.
	To the Hos within 24 h To the Fur completely	Medical	one)	ner: On the basis of examina and manner stated.	ation and/or in					
	Twith Con	~	29b. Signature and title of certifier			29c. Licens		29	d. Date signed (A	Aonth, Day, Year)
	iv		30. Name and address of person who co	ompleted cause of death (Itel	n 23a) (Tvne	1) 4.3 Print)	471		Februar	y 29, 2004
			Paul Armstrong M				#102, La	aurel . N	4D 20707	
1	Sta		31. Date filed (Month, Day, Year) MAR 0 2 200	32. Registrar's Signa	ature /	Louks				
	Registr	ar	INIAK O & ZUI	14 14	100	Laborator!				

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygien 2004 Amend Item# 2,3,26 per Phy. AACo.Health Dept.3/4/04 BEM Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death 7 : 05 PM 6 : 00 AM Month Day 24 February 25, **Physician** 2004 Harold Achilles /Medical 4b. City, Town, or Location of Deeth 4a Fecility Neme (If not institution, give street end number) 4c. County of Death Examiner Montgomery Village Sunrise Assisted Living Montgomery 6. Sex 1Å M 2□ F If Under 1 Year If Under 24 Hrs. Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthdey) Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 96 Yrs. Director Jun. 3, 1907 146-07-0242 Usuel Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Depertmant of Heelth and Mentel Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show says injury or other traumatic event, the Medical Examinat must be notified at once. 10a. Stete 10c. City, Town or Location 10d. Inside City Limits 10b. County Laytonsville MD 1 ☐ Yes 2 XNo Montgomery Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number 20882 USA 28801 Greenberry Drive Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2% No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married White 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify. Š 3 Nidowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Tidewater Oil Company Chemist 5+ 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 8 Edward Achilles Anna Wolfe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 28801 Greenberry Drive, Laytonsville, MD Marcia McComb/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Feb. 27 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Barranco & Sons, 21. Signature of Fune al Service Licensee P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line. Approximete Interval Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Carlingens Disease 10 years Examiner Due to (or as a consequence of) Examine Throat Cancor ed by the attending physiclen and datached for use es the bunal-transit The law requires that the death certificate be axecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760 Bladder Concer Physician/Medical 23b. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. cate has been signed by it page 2 should be datach 3 □ Probably 4 Unknown 1 ☐ Yes 2 ☐ No Š 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Be Completed this cartificate has 2 100 1 □ Yes 2 □ No 1 T Yes or Attanding Physician: after deeth. Director: After this cartifica the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Assisted Other: Hospital: Washing Home 5 □ Residence 6 DOther (Specify) Livino Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Dete of Injury (Month, Dey Year) 28b. Time of Injury 28c 28d. Describe how injury occurred 1 XNatural 2 🗆 No 1 Tyes investigation 2 Accident To the Hospital or Attar within 24 hours after dee To the Funeral Director completaly filled in by th 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 I Homicide 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Dewest Marisa M February 25, 2004 D47682 30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) Read, Olwey, Maryland, 20832 2901 olney-sandy spring Bennett Morrison 31. Date filed (Month, Day, Year) 32. Refistrer's Signature State MAR 0 2 2004 Registrar

ORIGINAL

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene 20008675 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 28, 2004 **Physician** February ' 2:05 A M Mary Lou Behrens /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 01ney Montgomery Montgomery General Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day Year) | Dec. 27, 1941 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country)
Utah **Funeral** 1□M 2QF Director 213-44-2991 62 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f ehow event, the Medical Examiner must be notified at No Yes 2 No Directo Maryland Montgomery Silver Spring 10e. Street and Number 10g. Citizen of What Country? ö 20904 USA 13121 Clifton Rd. or Hems 23a Funerai Pages 1 and 2 should be filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 by. 1 ☐ Yes 2 ☐ No Specify 3 Widowed 4 Divorced White Year or Dates *natural". Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If item 27 ie marked other than any injury or other treumatic event, If a Monea. Homemaker Own Home Yrs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Louise Prisk Max Spendlove 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5017 Swinton Dr. Fairfax, VA 22303 Lisa Brigham- Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State
* 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Crematory 02/29/2004 Brentwood, MD 21. Signature Funeral Service Licenses 22. Name and Address of Facility Hines-kinaldi Funeral Home 11800 New Hampshire Ave. Silver Spring, MD 20904 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition ENCEPHALOPATHY METABELIC **Physician** > 1 DAY resulting in death) /Medical Due to (or as a consequence of): Examiner FAILURE LIVER END STAGE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed CIRRHOSIS HEPATIC that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician hed for use as the burial UMENOUS of Vital Records, P.O. Box 68760. ARUSE (O)+ Physician/Medical IF FFM ALF 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Cher (specify) 4☐Pregnant at time of death 9 Unknown 9 Unknows signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed cate has been s page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy certificate 1 ☐ Yes or Attending Physician: ector. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 patient Medical Certification; To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No the Director: 6 Could not be determined 3 Suicide in by 1 Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after Voting 24 hours are To the Funeral Dir 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the ? 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) & S & Lu ILL DKOJ1 0 Avenue sauce Taloma 20912 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 0 1 2004 Registrar

			1 - For State Registrar AMEND#6perFH3			nd / Depa	artmer rtificat	nt of H	ealth a	and M		Reg. No.	2001	
	Physici /Medi	cal	Decedent's Name (First, Middle, La. ZACHARIA 4a. Facility Name (If not institution, giv.)	.H	BROC	ĽK	4h City	Town or	Location	of Death	2. Date of De Month MARCI	H I Pay	2002	
	Examir	ner	3325 Floral C	court		. last birthday)			ator	1	8. Date of Bir	M	ONTG	OMERY
-	Funeral Director			Х м 20 г	69	Yrs.	Months		Hours	Min.	8. Date of Bin (Month, De Apr 2	0°,1'9	34 J	Birthplace (State or Foreign Country). amaica
	e Maryland 3a-f show	ctor	Md Montgo	mery	10c. C	ity, Town or Lo Wh	eato							10d. Inside City Limits 1 A Yes 2 □ No
	th with th	rai Dire	10e. Street and Number 3325 Floral				2	Code 2090					en of What	.A.
036	72 hours after death with the Maryland "natural", or items 23a or 28a-f show bloat Examinet must be retified at	by Funeral Director	11. Marital Status 1 Never Married XXMarned 3 Widowed 4 Divorced	12. Was Decedent Armed Forces 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	?		Was Dece If Yes, spe 1 Yes		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto	ecify Yes or No Rican, etc.)		Black, W	mericen Indian, Thite, etc. amaican
Maryland 21215-0036	within 72 ho ene. then "natur ne Maulcal	Completed	15. Decedent's Ed (Specify only highest grades) Elementary/Secondary (0-12)	ducation ide completed) College (1-4or	5+)		kind of wo DO NOT u	ork done d ise retired	luring most)				d of Busine	·
	tygi ther	To Be Con	6th Grade 17. Father's Name (First, Middle, Last, James Brock			Build	ing	Ser	18. Mothe		(First, Middle		Sumame)	y Pubic Sch
	1 and 2 should be f Heelth and Mental F iem 27 ie marked of other treumatic eve	ř	19a. Informant's Name/Relationship (Gretel M. Brock			332	5 F1	ora	and Numbe	or or Aura	Whea	er, City or	Town, State	#20902
Baltimore,	permit. Peges 1 end i Department of Heelth Important: If Item 27 any injury or other tr once.		20a. Method of Disposition Burial 2 Cremation 3 C 4 Donation 5 Other (Specif	0 0	.	Place of Dispo cometery, create the Of	natory or d Hea	other plac Ven		3/6/		Silv	er S	or Town, State pring, Md
Bal	Depar Depar Impor		21. Signature of Funeral Service Light Local 23a. Part 1. Enter the disease, or com	Annue	ll_		246_	N. \	√ash:	ıngt	Home on St	, Ro	. 20 ckvi	850 11e, Md Approximate
	Physician /Medical Examiner		shock, or heart laildre. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each	TAS	ATIC			ATIC					Interval Between Onset and Death 28 Months
3760,	ate be executed hysician and he burial-transit	icai Exaniner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or a: C. Due to (or a: d.										
.O. Box 68	The law requires that the death certificate has been signed by the attending phyoage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fet	al death 3	Ectopic p Other (s)					23	3d. Date of o	delivery Day Year
٥.	quires that in signed b uid be deta	by	Part II. Other significant conditions of	ontributing to death	but not re	sulting in the u	nderlying (cause give	en in Part I.					to the cause of death? Probably 4 Unknown
I Records,		Completed									24a. Was auto perfo		24b. Were prior to death	
Vital	Physician: this certificant al director.	o Be	25. Was case referred to medical examiner? 1 Yes YYO	Hospital: 1 ☐ Inpat	ient 2	☐ ER/Outpatier	nt 3 🗆 D(Othe			(Check only one		□Other (Si	pecify)
sion of	Jing After fune	ation: T								Home PResidence 6 Other (Specify) 28d. Describe how injury occurred			,	
Division	To the Hospitel or Attent within 24 hours after death To the Funarel Director: completely filled in by the	Certification:							City or To	wn, State)		Rural Route Number,		
	To the Mospitel or within 24 hours affer To the Funarel Dir completely filled in	edical		ysician: To the bes niner: On the basis and manner s	of examin									
)	within To th comp	Me	29b. Signature and title of certifier	Ma	u	0	29	c. License	33229)			signed (Mc	onth, Day, Year) 2004
	13		30. Name and address of person who	han M.D	. 50	W. E		stor	Dr	#30	3 Rocl	kvil	le, M	1d 20852
	Sta Regist	ate	31. Date liled (Month, Day, Year)	32. Regis	rar's Sign	nature &	10	acti	1					

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Mary	and / Depa	artment of F rtificate of	lealth and M <i>Death</i>		giene 2 () Reg. No.	04	0867
	Physici /Medio		Decedent's Name (First, Middle, La Rudolph	william		Brlansk	У	2. Date of Dea	26, 2004		3. Time of Death 11:00P.
	Examir		4a. Facility Name (If not institution, gives 5 Greendale Pl	ace	4b. City, Town, or Location of Death Greenbelt			Prince Geo			
	Funeral Director		208-22-7837	Sex 7. Age (In	yrs. last birthday) 84 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da June 11	,1919	Coun	lace (State or Foreig try) Sylvania
	Maryland	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Prince	George's	City, Town or Lo					10	0d. Inside City Limits
	3s or 28s	ii Direc	10e. Street and Number 5 Greendale Place	е		10f. Zip Code 20	770		10g. Citizen of V		-
980	s 1 and 2 should be filed within 72 hours after deeth with the Maryland if Health and Mental Hygiene item 27 ie marked other then "natural", or Iteme 23s or 28s-f show other traumatic event, the Medical Exertine traumatic event, the Medical Exertine traumatic event,	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 XYes 2 ☐ No If Yes, Give Year or Dates: WW]		Was Decedent of H If Yes, specify Cubin 1 ☐ Yes 2 ☑ No	fispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Rac Blac Specify	e - America ck, White, e	etc.
21215-0036	in 72 ho n "natur	Completed	15. Decedent's E (Specify only highest gr	ade completed)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of work	rking 16b. Kind of Business/Industry			ustry
	2 should be filed withir and Mental Hygiene. Ie marked other then aumetic event, Ira Mi		Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last			ographer	18. Mother's Nam	Federal Governm			ernment
Maryland	should be ind Mental marked o	To Be	Rudolph	Brl	.ansky		Mary			Tkac	ik
Mar	d 2 sho th and th and 17 le m traum		19a. Informant's Name/Relationship (Mary A. Brlansky	• •			and Number or Run lace Gree				
Baltimore,	2 = 2		20a. Method of Disposition 12 Burial 2 Cremation 3 C 4 Donation 5 Other (Speci	Removal from State	b. Place of Dispo cemetery, crei	osition (Name of matory or other place	ce)	Date	20c. Location -	City or To	
Balti	permit. Peg Department Important: eny injury		21. Signature of Funeral Service Lice	Baywood	V 000 44	nald V. 1 00 Powde	ss of Facility Borgwardt MILL Roa	Funeral	Home,	Dλ	land 20705
8760,	death certificate be executed e attending physicien and d for use as the buriat-transit	dical Examiner	23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, feeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Arteric	sons Di asequence of): osclero osequence of): of the asequence of):	sease sis Bladde:		or respiratory ar	rest,		Approximate Interval Between Onset and Death
O. Box 6	that the death certified by the attending detached for use as	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of print Compared to the compared to th	Fetal death 3	□Ectopic pregnancy □ Other (specify) _	1		23d. Dat Mo	e of deliver	ry Day Year
0	sign d be	ed by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23e. Did tobacco use contribute to the ca		
al Records,	3 0								med?	Were autoporior to com death?	psy findings available pletion of cause of 2 No
Division of Vital	To the Hospitel or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification; To Be	25. Was case referred to medical examiner? 1 Yes	28a. Date of Injury (Month, Day Yea		f 28c. Injur Wor M 1 🗆	4 🗀 Nursing no	me 5 Resid 28d. Describe h	lence 6 Other	ed	
	To the Hospitel or within 24 hours atte To the Funeral Dir completely filled in In	edicai C		hysician: To the best of my miner: On the basis of exar and manner stated.							
	M Vithin Comp	Me	29b. Signature and title of cartilier			29c. Licens D3	e number		29d. Date signed Februa		7, 2004
			30. Name and address of person who Vicken Poochil	completed cause of death cian, M.D.	(Item 23a) (Type, 5632 Ar	Print) nnapolis	Rd. Bla	adensbi	ırg, Mo	1. 20	710

State Registrar

31. Date filed (Month, Day, Year)
MAR 0 3 2004

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 2004 08678 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** February 28,2004 <u>Harry Anthony Bresnahan</u> /Medical 2:50A 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Silver Spring
If Under 1 Year | If Under 24 Hrs. Mariner Health Care-Silver Spring
5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Montgomery 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1√2 M 2 □ F Hours Months Director 216-44-6606 90 Oct.1,1913 Washington, DC Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be ince.

Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Musical Examiner must be natified at once. 1 ☐ Yes 2 ☐ No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 403 Lanark Way 20901 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: ₩₩ T.T Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 1 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced WW II White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bureau of Engraving Ass<u>istant Superintendant</u> and Printing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William Archer Bresnahan Florence Steadman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) e 403 Lanark Way Silver Spring Maryland 20901

20b. Place of Disposition (Name of cemetery crematory or other place)
Metropolitan
Crematory

Mar. 1, 2004

Alexandria, Vir. Marilyn T. Bresnahan Wife 3altimore, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Mar. 1, 2004 Alexandria, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901 JOW-> Pert1. Enter the disease, or complications that causes the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Arteriosclerotic Heart Disease vears /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last physicien and the burial-transit certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical use as the attending IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? Year Month Day 5 Other (specify) P.0. 1 ☐ Yes 2 ☐ No 9 Unknown signed by I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Failure to Thrive, Anorexia, Malnutrition 1□Yes 2晃No 3□Probably 4□Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has certificate ha autopsy performed? 1 Yes 2 No Be (25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification; 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 1 XNatural 5 Pending within 24 hours after death. To the Funaral Diractor: A investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide the Hospital 1 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of Zertifier 29c. License number 29d. Date signed (Month, Day, Year) 10 2 0101 D 09834 March 1, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Barry Rosenbaum, M.D.
31. Date filed (Month, Day, Year) 3720 Farragut Avenue Kensington, Maryland

Registrar DHMH 17 Rev 1/2001

State

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2004

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32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene? 08679 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** ам 2004 James J. Boyd March 5:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mariner Health- Silver Spring Silver Spring
If Under 1 Year | If Under 24 Hrs. Montgomery 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1⊠M 2□F Days Hours Min. Director 106-20-5779 75 Dec. 9, 1928 New York Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow event, the Medical Exeminer must be notified at 1 ☐ Yes 2 ☑ No Director Maryland Montgomery Wheaton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö or itama 23a 2719 Fenimore Road 20902 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊕Yes 2 □ No If Yes, Give Year or Dates: 1952–53 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after Hygiene. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) 12 Construction Project Manager marked other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othe any injury of other traumatic avent once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ပ James Boyd Mary McBride 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marguerite E. Boyd/ Wife 2719 Fenimore Road, Wheaton, MD 20902 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State March 5, * 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 2004 Alexandria, Virginia 21. Signature of Funeral Service Licensee Ken Skiles Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on eech line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Urinary Tract Infection /Medical Due to (or as a consequence of): Examiner Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner Hospital or Attanding Physician: The law requires that the death certificate be executed Parkinson's Disease physicien are the burial-t Due to (or as a consequence of): Box 68760 Physician/Medical Anemia as IF FEMALE: 957 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) P.O. 1 ☐ Yes 2 ☐ No the 9 Unknown 9 ☐ Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 2X No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has bracter, page 2 s autopsy page performe 1 ☐ Yes director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: Certification: To 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Dale of Injury (Month, Day Year) 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No after death Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 - Homicide within 24 hours at To the Funaral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) 10 D00058965 March 4, 2004 30. Name and address of person who completed cause of death (frem 23a) (Type, Print) Saima Khawaja M.D. 11119 Rickville Fike, #100, Rockville, MD 20852 31. Date filed (Month, Day, Year) State 32. Registrar's Signature MAR 05 Registrar

DHMH 17 Rev 1/2001

		-	For State Registrar	State of Marylan	d / Depa <i>Cei</i>	artmer	nt of H	ealth a D <i>eath</i>			Reg. No.	2004	086	80	
	41.		1. Decedent's Name (First, Middle, Last)						1	Date of Dea Month	ath Day	Year	3. Time of		
	Physicia		Esth	er M. Beta	ncourt	:			I	Februar		, 2004	4:20	A ^M	
,	/Medic Examin		4e. Fecility Name (If not institution, give str	eet and number)		4b. City,	Town, or	Location o	f Death		4c.	County of Deeth			
		•	Suburban Hospital				В	ethes				Montgom	ery		
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.	last birthday)	If Unde Months	r 1 Year Days	If Under 2 Hours	Adim	B. Date of Birt (Month, Da	v Yearl	Cou	plece (State o	_	
	Director		213-44-6218	u 2∑F 84	Yrs.	Mortario	54,5	1.00.0	(Octobe	r 5, 1	919 Mass	achuse	tts	
	9		Usual Residence of Decedent	100 Cib	y, Town or Lo	antia n							10d. Inside Cit	by Limite	
	how	_	10a. State 10b. County										1 🗆 Yes		
	e Ma	cto	Maryland Montgomer	У	Chevy	_									
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	death with the Maryland	al	4716 Bradley Blvd.				2081.				United States				
	dea dea	Funeral	11. Marital Stetus	Was Dece If Yes, spe	dent of Hi city Cuba	ispanic Orig in, Mexican	gin? (Spec , Puerto R	ify Yes or No ican, etc.)	-	 Race - Amer Black, White 					
õ	or It		1 🖄 Never Married 2 🗆 Married		1 Yes 2□ No Specify: Cuban						Specify: White				
9500-61212	within 72 hours after death with the Marylan jees.	d by	3 Widowed 4 Divorced	Year or Dates:	160 Dage	dant's Lla	al Ossus	ation			16h Ki	nd of Business/li	nduetni		
7	national	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16 Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)							100. KI	10 01 003111033/11	loustry			
7	withir	m d	Elementary/Secondary (0-12)	College (1-4or 5+)		Analyst					Bar	anking			
	o filed within 72 I Hygiene. other than "naf rant, the Medic	ပိ	17. Father's Name (First, Middle, Last)		1			18. Mothe	r's Name	(First, Middle,	Maiden	Sumame)			
ב	ed at b	Be	Flore Senebog												
چ	2 should and Men la marke raumatic	2	19a. Informant's Name/Relationship (Typ	e Print)	19b Mailir	na Addres	s (Street a	and Numbe	or or Rural	Route Numbe	er. City o	y or Town, State, Zip Code)			
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	s 1 and 2 of Health Item 27 other tra		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State									cation - City or T			
و	500-1										Reth	thesda, Maryland			
	it. Part rtant rtant njury		*4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses				_								
Baltimore,	permit. Page Department Important: h eny injury o		Jacob H. Burg	M0130	15 Ro	bert A	A. Pun	phrey	Tunera	al Home/	Bethe	sda-Chevy yland 208	Chase,	Inc.	
			23a Part 1 Extended disease or complic									ylarki 200	Approximate Interval Bet	9	
10	Pnysician /Medical Examiner	er	Immediate Cause (Final disease or condition resulting in death) Onset an O										Onset and (Death	
68760,	icate be executed physicien and s the burial-transit	dical Examiner	cause, Enter Undertying Cause (Disease or injury that initiated events csulting in death) Last d.	Due to (or as a conseq	Due to (or as a consequence of):										
P.O. Box (The law requires that the death certifica ate has been signed by the attending ph page 2 should be defached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 125 No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1							23d. Date of delivery Month Day Year		Year		
ds, P	w requires that been signed b should be deta	b	Part II. Other significant conditions confi	ributing to death but not res	sulting in the c	anderlying	çause giv	en in Part I		23e. Did t		se contribute to	the cause of cobably 4 🗀		
Vital Records,	eicien: The law rec certificate has beel irector, page 2 shou	Completed	Lor	gullum	al	?e				24a. Was auto		24b. Were autoprior to codeath?	topsy findings ompletion of c	available ause of	
	the cate	Ö								1□ Yes	2 N o	1 ☐ Yes	2 No		
Ħ	cian ertifi ector	Be	25. Was case referred to medical examiner?	ospital:			Oth	000		(Check only o					
5	Phyeician: The I r this certificate har ral director, page	ို	T Yes 27 No	Inpatient 2	ER/Outpatie		WA	4 1 140		8d. Describe		6 Other (Spec	ufy)		
ב	ding F h. After funera	on:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of fnjury (Month, Day Year)	28b. Time o Injury		28c. Injur Wor			ou. Describe	now injui	y occurred			
Division of	deat deat ctor: y the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Locatio						n (Street and Number or Rural Route Number, Town, State)					
	To the Hospital or A within 24 hours after To the Funeral Direction Completely filled in D	edical C		ician: To the best of my known: er: On the basis of examination and manner stated.										s)	
	To the To the To the Somp	¥	29b. Signature and title of certifier			2	9c. Licens	e number	_			te signed (Month			
			1 lin Ol	11/187/	00		0	22	17		Feb	cuary 27	, 2004		
	10		30. Name and address of person who con	mpleted cause of death (Ite	m 23a) (Type	, Print)			/_/_						
	•		Gita Bakshi, M.D.	9406 Old Geo	rgetow	n Ro	ad, E	Bethes	sda,	Maryla	nd 2	0814			
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sign		4	sock	2							

DHMH 17 Rev 1/2001

Betancourt, Esther 4 am x127/04

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Hampton Baumgartner, Jr. February 11:40A M 28, 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Bethesda Maplewood Health Care Center Montgomery 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 11X M 2□ F Hours Director Maryland 098-12-6291 84 Feb. 6,1920 Usual Residence of Decedent the Maryland 10a. State 10c. City. Town or Location 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 10d. Inside City Limits Md. 1 Tx Yes 2 □ No Bethesda Directo Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 9707 Old Georgetown Road. #1216 20814 U.S.A. death 12. Was Decedent Ever in U.S. Armed Forces?

1 1 12 Yes 2 □ No If Yes, Give Year or Dates: 1946 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. fited within 72 hours after 1 Never Married 2 Married Baitimore, Maryland 21215-0036 1346 1 ☐ Yes 2 ANo Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be fitted within 73.
Department of Health and Mental Hygiene.
Important: if item 27 is marked other than "ru any injury or other traumatic event, the Media once." (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Lawyer Private Practice 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John H. Baumgartner, Sr. Theodora Clarke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Antoinette M. Baumgartner/Wife 9707 Old Georgetown Rd. #1216 Bethesda, Md. 20814 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Cedar Hill Cemetery March 3,2004 Suitland, Maryland 21. Signature of Fundral Service Licensie 22. Name and Address of Facility DeVol Funeral Home 2222 Wisc. Ave., N.W. Wash. D.C. 20007 MIBIL 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Cerebral Vascular Accident 3 Months resulting in death) /Medical Due to (or as a consequence of): **Examiner** Cerebral Vascular Arteriosclerosis 5 Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 the attending physician Physician/Medical JF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) detached ☐Yes 2☐No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ ed bluods Coronary Artery Disease 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No Diabetes Mellitus has 24a. Was an page 2 autopsy performed? certificate 1 🗌 Yes 2 🔀 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 A Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 🗓 No this 2 EN/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 XNatural 5 Pending investigation To the Hospital or much within 24 hours after death.

To the Funeral Director: Af 1 🗌 Yes 2 🗌 No 2 Accident 6 □ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0013187 March 1, 2004 ad address of person who completed cause of de em 23a) (Type, Print) Neill Kennedy M.D. 5530 Wisconsin Ave. Chevy Chase, Md. 20815 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 04 2004 Registrar

DHMH 17 Rev 1/2001

Please Ty

ype or Print in Black Indelible Ink. Ensure	All Copies A	re Leg	ible.	
State of Maryland / Department of Health and Certificate of Death		i No.	0 ц	08682
10	2. Date of Death Month	Day	Year	3. Time of Death

Physicia: /Medica Examine

Funeral Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23s or 28s-f show any injury or other traumatic avant, the Medical Expruser medical configuration of the profittion at once.

Baltimore, Maryland 21215-0036

Pnysician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Lifrector: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

	1 - For State Registrar	State of Mary	Cer	tificate of	Death		eg. No.	04	000	0 2
	1. Decedent's Name (First, Middle, Last)	1 10				2. Date of Deat Month	th Day	Year	3. Time of D	Death
n d	RUSSELL	L. BALD.	ER501	ν		Februa			9:00	Рм
r	4a. Fecility Name (If not institution, give st	treet and number)			Location of Deat	h	4c. County			
	10209 Carson Place			Silver				gome		
	5. Social Security Number 6. Sex	7. Age (In)	vrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Dec. 4	Year)		plece (State or intry)	Foreign
	578-34-2230 Usual Residence of Decedent		82 Yrs.			Dec. 4	, 1921	Vir	ginia	
	10a. State 10b. County	10c	City, Town or Los	ation				T	10d. Inside City	y Limits
ō	Maryland Montgome	erv	Silve	r Spring					1 🗆 Yes	2 ⊠ №
e C	10e. Street and Number			10f. Zip Code		1	0g. Citizen of	What Cou	ntry?	
by Funeral Directo	10209 Carson Place	2		20901			U	SA		
Jera		2. Was Decedent Ever	in U.S. 13. V	Vas Decedent of H	ispanic Origin? (S	specify Yes or No- to Rican, etc.)	14. Rac		can Indian,	
7	1 ☐ Never Married 2 ☑ Married	Armed Forces? 1 ☐ Yes 2 ☒ No	1	Yes 2 No		to rican, etc.)		ck, White		
5	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	'	165 25 10	эрвопу.		Specii	ÿ:Wh i t		
Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Deced (Give	ent's Usual Occup kind of work done OO NOT use retired	ation during most of wo	rking	16b. Kind of B	usiness/lr	ndustry	
E	Elementary/Secondary (0-12)	College (1-4or 5+)		ice Mana			Auto D	eale:	rship	
	8 17. Father's Name (First, Middle, Last)		Derv	ree mana		me (First, Middle, I				
Be	George Balderson					te Peed				
0	19a. Informant's Name/Relationship (Typ		19h Mailin	n Address (Street		ural Route Number	City or Town	State Zi	n Code)	
	Freda L. Balderson			-		Silver Sp			20901	
	20a. Method of Disposition		b. Place of Dispos cemetery, cren		-	Date	20c. Location			
	1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)		cemetery, crem ort Linc			2004	Dwontre	o d	Marylan	nd.
	21. Signature of Funeral Service License				maryran	iu				
	De sach	0,	F1	ancis J.	Collins	Funeral	Home l	nc.	, MD 20	901
	23a. Part 1. Enter the disease, or complic		Approximate Interval Betw							
	shock, or heart failure. List only on Immediate Cause (Final			Onset and Do	eath					
	disease or condition resulting in death)	Pancreation Due to (or as a cor		- riogies	SIVE			-	3 month	15
	Sequentially list conditions 5.									
ner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying	Due to (or as a cor	sequence of):							
edical Examine	Cause (Disease or injury that initiated events c. resulting in death) Last									
Ä	resulting in death) Last	Due to (or as a cor	sequence of):							
olca	d	•								
	IF FEMALE:	3c. If yes, outcome of pre	agnanov				024 D			
เลา	in the past 12 months?	1 Live birth 2 ☐ 4 Pregnant at time	Fetel death 3	Ectopic pregnancy Other (specify)				ite of deliv		ear
ysic	1 Yes 2 No 9 Unknown	9□ Unknown	0.000.	Cities (specify)						
Completed by Physician/N	Part II. Other significant conditions con	tributing to death but no	resulting in the ur	iderlying cause giv	en in Part I.	23e. Did tol	bacco use con	tribute to	the cause of de	ath?
D D						1 □ Ye	es 2 🖾 No	3 🗌 Pro	babiy 4 □Ur	nknown
ete						24a. Was a	ın 24b.	Were aut	opsy findings a	vailable
μĸ						autops	med?	death?	mpletion of car	use of
ပို	25. Was case referred to medical				26 Place of De	ath (Check only on		1 🗌 Yes	2 No	
To B	avaminer?	ospital:	2 ER/Outpatien	t 3□ DOA Oth	00	dome 5 K Reside		ner (Sneci	(fv)	
n: –	27. Manner of Death	28a. Date of Injury (Month, Day Yea		28c. Injur Wor	y at	28d. Describe ho			97	
atio	1 XNatural 5 Pending 2 Accident investigation	(Month, Day 1 do	r) Injury		Yes 2 □ No					
tific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - building, etc. (Si	At home, farm, stre	et, factory, office		28f. Location (St City or Town	treet and Numi	ber or Rur	al Route Numb)e <i>r</i> ,
Cer		2								
Medical Certification:		sician: To the best of my ner: On the basis of exa- and manner stated.								
Me	29b. Signature and title of certifier	_ //		29c. Licens	e number	2	9d. Date signe	d (Month,	Day, Year)	
	> llahul	& Hus	sa.	рообо	050		March	1, 2	004	
			~							
	30. Name and address of person who so	mpleted tarries of death	(Lam Eta) (Type)	Pr n						

State Registrar 31. Date filed (Month, Day, Year)
MAR 0 4 2004

32. Registrar's Signature

oaks

	•	1 - For State Registrar		State of M	larylan	•	artmen rtificat			and M	lental H	_	e •.20() [0868
Physici	an	Decedent's Name (First, Mi Geoffrey Bun									2. Date of D Month Februa	D	28, 20	Year 004	3. Time of Deal
/Medic Examin		4a. Fecility Name (If not institu	tion, give s)				Location o	of Death		4	c. County of	f Death	
Funeral Director		213 King Geo 5. Social Security Number	6. Sex	reet M 2□F	ge (In yrs.	last birthday) Yrs.	If Under Months	napo 1 Year Days	If Under: Hours	24 Hrs. Min.	8. Date of E (Month, I June			9 Rirtho	lece (State or For try) Jersey
		217-58-4253 Usual Residence of Decedent 10a. State 10b. Cou	nty			y, Town or Lo	cation				ourc .				Od. Inside City Lir
28a-1 sho	Director	Maryland Ann	e Aru	ndel	7	nnapol	.is	Code				100.0	itizen of Wh	at Cour	1 Yes 2
No.		213 King Geor	an St	root				401				_	ited S		-
nous aller death with the maryland tural', or items 23a or 28a-1 show al Examinat De notilied al	by Funeral	11. Marital Status 1 Never Married 2 Nover Ma	Married	12. Was Deceden Armed Forces 1 Tyes 2 If Yes, Give Year or Dates	?] No		Was Dece	dent of Hi city Cuba	spanic Ori n, Mexican Specify:	gin? (Spe n, Puerto	ecify Yes or N Rican, etc.)	1	14. Rece		an Indian, etc.
n 'n	Completed	15. Dece (Specify only hig Elementary/Secondary (0-1		cation completed) College (1-40)	.54)	16a. Deced (Give	dent's Usu kind of wo DO NOT u	rk done d	turina mosi	t of worki	ng	16b.	Kind of Busi		
7 77 2	E	Clementary/Secondary (0-1	-/	4	3+)	Inc	lepend	dent	Scho	lar		se	lf em	olov	ed
0 = 0 3	Be C	17. Father's Name (First, Midd	lle, Last)				_				(First, Midd	le, Maide	n Sumame,	j -	
	10	Gerald Bunke	r						Elair	ne Fo	orđ.				
and self	1 -	19a. Informant's Name/Relati	onship (Ty)	oe, Print)		19b. Mailir	ng Address	(Street a	and Numbe	er or Rura	il Route Num	nber, City	or Town, S.	tate, Zip	Code)
of Heali		Flor A. R. Bu 20a. Method of Disposition 1 Burial 2 Cremati	,		20b. P	213 Place of Disponentery, crem	sition (Na	ne of	rge St	t. A	napol ese		MD 214 Location - C		wn, State
ment ant: I		'4 □Donation 5 □ Othe		omovar nom otal		altimor					1, 200	Ja Ba	ltimo	re,	MD
Department important: If any injury o		21. Signature of Funeral Serv	ce License	emus	Dú				s of Facilit	Jo					al Home, mD 2140
charming the execution of earth carrillicate be executed to the earth of the east the burial-transit	cal Examiner	shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Due to (or a	Rec s a conseq	juenca ol).	Can	Cer					p1 - p1	1	Onset and Death
e attending p	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	2	3c. If yes, outcom 1□Live birth 4□Pregnant 9□Unknown	2 🗌 Feta	ıl death 3 [Ectopic p						23d. Date Monti		ory Day Year
pang pa de	þ	Part II. Other significant con	titions con	ntributing to death	but not res	sulting in the u	nderlying (ause give	en in Part I			tobacco	_	oute to th	ne cause of death
	Completed										1 Yes	topsy rformed? 2 2 N	/ pri	or to cor	psy findings avail npletion of cause 2 No
	o Be	25. Was case referred to men examiner? 1 Yes 2 No	-	lospital:	tient 2	ER/Outpatier	at 2 1 0	Othe	ac-		n (Check only	_	€ ∏Other	(Canada	.1
this aldi	on; To	27. Manner of Death 1 Natural 5 Pe	nding estigation	28a. Date of Ir (Month, L		28b. Time o	-	8c. Injury Work			28d. Describ				//
After	훈	- ELIMOUUDIN			njury - At h	ome, farm, sti					28f. Location	(Street a	and Number	or Rum	1 Davida Mumbas
death. stor: After	ertificati	3 ☐ Suicide 6 ☐ Co	uld not be ermined	28e. Place of l building,	etc. (Specii	fy)	reet, factor	y, office				own, Sta		OI MUIA	I Houte Number,
death. stor: After	dical Certification;	3 Suicide 6 Co 4 Homicide de	uld not be ermined fying Phys	sician: To the bener: On the basis and manner	st of my kno	owledge, deat	h occurred	at the tim	ne, date an pinion, dea	d place,	City or 7	own, Sta	(s) and man	ner as si	ated.
death. stor: After	Medical Certification	3 Suicide 4 Homicide 29a. Certifier (Check only 1 Cert	uld not be ermined fying Physical Examin	building, sician: To the be- ner: On the basis	st of my kno	owledge, deat	h occurred vestigation 29	at the tim , in my of	pinion, dea a number	d place, th occurr	City or 7	e cause(e, date at	(s) and mani nd place, an	ner as si nd due to (Month,	ated. the cause(s) Day, Year)
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			1 - For State Registrar	State of Ma	arylario 	Cer	tificate o	of Death	7		eg. No.	2004	08681
	Physicia /Medic		Decedent's Name (First, Middle, Last DOROTHY H.	ARTGE		вон	EHM			Month ebruar	y 27	, 2004	9:15 A M
	Examin		4a. Facility Name (If not institution, give				4b. City, Tow		of Death			County of Death	
	Funeral		1526 ST. STEPHENS 5. Social Security Number 216-46-8701 10		RD • (In yrs. las 75	it birthday) Yrs.	Crowns If Under 1 Ye Months Da	ar If Unde	Min.	B. Date of Birth (Month, Day ec. 10	Year)	Anne Aru 9. Birthi Cou	indel place (State or Foreign ntry) yland
	Director		Usual Residence of Decedent							cc. 10	,		10d. Inside City Limits
	Marylan I-f ahow	tor	Maryland Anne Aru	ndel		Town or Lo ISVill							1 Yes 2 XNo
	with the	al Director	10e. Street and Number 1526 St. Stephens	Church Ro	oad		10f. Zip Coo	21032		1	0g. Citiz	en of What Cou. . A .	ntry?
326	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23a or 28a-f ahow ther than Medical Examera court be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 💆 Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:			Was Decedent f Yes, specify 0 1 ☐ Yes 2∏			ify Yes or No- icen, etc.)		4. Race - Ameri Black, White, Specify: White	etc.
9500-612	be filed within 72 houral Hygiene. Ind other than "natural avant, in a Wed Fall	Completed	15. Decedent's Ed (Specify only highest grad	le completed)		16a. Deced (Give life.	dent's Usual Oc kind of work do DO NOT use re	cupation one during mo tired)	ost of working	7	16b. Kin	d of Business/In	ndustry
717	d withi	mo	Elementary/Secondary (0-12)	College (1-4or 5)+)	Secre	tary					Law	
Maryland 21	e d la b	To Be C	17. Father's Name (First, Middle, Last) Alan McCaule	y Hart	ge				her's Name (Agnes	First, Middle, Bell	_	Gu <i>mame)</i> Ones	
ary	should and Men is marks	-	19a. Informant's Name/Relationship (7	ype, Print)								Town, State, Zij	
	end 2 ealth a m 27 i		William Alan Boehm	/ Son	20h Bla			_	Churc			ownsvil.	Le, MD 2103
Baltimore,	Peges 1 end 2 should nent of Health and Mer int: If Itam 27 ia marke ury or other traumatic		20a. Method of Disposition 1 Durial 2 Cremation 3 4 Donation 5 Other (Specify		Hill	ce of Dispo netery, crer Lcrest	sition (Name o natory or other Memor: Garden:	place) ial	3/1/2				Maryland
Balti	permit. Pege Department Important: If any injury or		21. Signature of Funeral Service Licen		A 100							ns Funer aryland	ral Home 20715
58760,	Interest of execution of the private of execution of the private o	edicai Exan iner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as b. Due to (or as c. Due to (or as d.	a conseque	ence of):	irte) d	îsca.) (lyear
P.O. Box 68	The law requires that the death certifical ate has been signed by the attending phyage 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 (XNo 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant al 9 ☐ Unknown	2 Fetal d	ieath 3∈]Ectopic pregn.] Other <i>(specif</i>)				2	3d. Date of deliv Month	rery Day Year
ds, P.	signed by	by	Part II. Other significant conditions o	ontributing to death b	ut not result	ting in the u	nderlying cause	given in Par	tl.		bacco us es 2 🖸		the cause of death?
Division of Vital Records,	The law requir	Completed								24a. Was a autop: perfor	sy m ę d?		opsy findings available impletion of cause of
Ita		Be	25. Was case referred to medical examiner?	11-					ce of Death	(Check only or	10)		
n of V	ng Physio After this co Ineral dire	၉	1 ☐ Yes 2 🖾 No 27. Manner of Death 1 ☑ Natural 5 ☐ Pending	1 Inpatie 28a. Date of Inju (Month, Da	ent 2 E	R/Outpatier 28b. Time o Injury	f 28c.	Injury at Work?	28	e 5 Resid 8d. Describe h		Other (Speci	fy)
)ivisio	To the Hoapital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.	Certification;	2 Accident investigation 3 Suicide 6 Could not by 4 Homicide determined	28e. Place of Inj	ury - At hom c. (Specify)	ne, farm, str		1 Yes 2		8f. Location (S City or Tow		Number or Run	al Route Number,
	e Hoapital 24 hours a Funeral (edicai Ce	(Check only 2 Medical Exam	ysician: To the best niner: On the basis of	f examination	ledge, deat on and/or in	h occurred at the vestigation, in r	ne time, date ny opinion, d	and place, ar	nd due to the o	ause(s) a late and	and manner as s place, and due t	stated. to the cause(s)
	To the within 2. To the Complet	Med	29b. Sign ture title of certifi	and manner st	attu.		29c. Li	ense numbe	or	1 2	29d. Date	signed (Month,	Day, Year)
	ř šř S		Mattha	15			D.	518	19		Feb	ruara	27,2004
			30. Name and address of person who	completed cause of o	death (Item :	23a) (Type,	Print)	las	cT s	site	Sal	Ann	27,2004 epilis, MO
A	Sta Regist		31. Date filed (Month, Day, Year) MAR 0 1	32. Paristr	rar's Signatu		haut ,						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item#26 State of Maryland / Department of Health and Mental Hygiene 2004 08685

1- For per Phy. 3/2/04 Phys. 3/2/04 AACo. Health Dept. BWE Certificate of Death Reg. No. 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) 26, **Physician** February 2004 1726^M Mildred Louise Brown /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Memorial Hospital Easton Talbot If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex Social Security Number **Funeral** 1 M 2 F Sept. 10, 1919 Virginia Director 579-32-3024 Usual Residence of Decedent 84 the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County f Health and Mental Hygiene. Item 27 Is marked other then "natural", or Items 23s or 28s-f show other traumatic event, the Medical Expiritive count be notified at 1 Yes 2 No Director Maryland Caroline Denton 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 21629 United States 21933 Shore Highway Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 (No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 ☐ Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) own home homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mary Jane Langgler ပ Homer Schaeffer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21933 Shore Highway Denton, MD 21629 Robert Brown/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
eny injury or ot
once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) March 2, 2004 Annapolis, MD Hillcrest Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service Licens John M. Taylor Funeral Home, Inc Scott Kommand 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition SEPSIS **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death Year in the past 12 months? Month Day 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No. detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significent conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by DEHYDRATION 1 Yes 2 No 3 Probably 4 Unknown ACUTE RENAL BAILURE 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? page 1 Yes 2 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. injury at Work? 27. Manner of Death 28d. Describe how injury occurred or Attending Injury 1. Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation the hours after deal 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 1 within 24 hours a To the Funeral C pellil 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month. Dav. Year) 29b. Signature and title of certifier 359135 02/26/04 30. Name and add person who completed cause of death (Item 23a) (Type, Print) DR ADESANOYE 215 Bloomingdale Ave. Federalsburg, MD 21632 31. Date filed (Month, Day, Year) 32. Registrar's Signature MAR 0 2 2004 Registrar

Brown,

State of Maryland / Department of Health and Mental Hygiene ? 08686 For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 2004 March 4:45 A Brown Doris Ann /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Corsica Hills Genesis Elder Care Centreville Queen Annes If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** Hours 1 ☐ M 2 🕱 F Days Director 214-42-9111 58 Mar. 28, 1945 Maryland Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits i Health and Mental Hygiene. Item 27 is marked other than "naturel", or Items 23a or 28e-f show other traumatic event, the Medical Examinar must be notified at or items 23a or 28e-f show 1 Yes 2 No Directo Maryland Caroline Ridgley 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with till Department of Health and Mental Hygiene important: If item 27 is marked other than "naturel", or items 23a or 2 any injury or other fraumatic event, the Medical Examinet must be recons. 11425 Holly Road by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Manager Electro Therm 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ٩ John Wesley Butler Sarah Catherine Murray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Randolph H. Brown / Husband 11425 Holly Road, Ridgley, Maryland 21660 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Sandtown Cemetery 03/06/2004 Hillsboro, Maryland 21. Signature of Juneral Service Licensee 22. Name and Address of Facility Bennie Smith Funeral Home 426 Dover Street, Easton, Maryland 21601 tun runce 23a. Pand Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Concer **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit been signed by the attending physician and should be detached for use as the burial-trai Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknowh Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 1 Tyes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed2 Yes 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٥ 1 Yes 2 No 3 DOA this 28a. Date of Injury (Month, Day Yeer) 27. Manner of Death 28b. Time of Medical Certification: 28c. Injury at Work? 28d. Describe how injury occurred After Natural 2 Accident 5 Pending death. investigation 1 Yes 2 No the within 24 hours after deat To the Funsral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital per 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Dey, Year) 31036 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Drive Chester, MD 21619 we 108 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2004 08687 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 12/215RM Physician MARCH JOY G. BERRIER /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BACTIMONE
If Under 1 Year If Under 24 Hrs. UNIVERSITO 7. Age (In yrs. last birthday) Dec. 12/1 8. Date of Birth (Month, Day, Year) APR 2 1931 Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days Hours 1 □ M 2 🕅 F 72 Yrs. 579-38-1626 WASHINGTON D.C. Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23e or 28a-1 show any injury or other treumatic event, Tre Madical Exactliner must be rediffied at once. Y☐ Yes 2 No TRAPPE **Funeral Director** TALBOT 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code USA 3857 MAIN STREET 21673 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: Specify: WHITE Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be EDITH GOODACRE ပ CARL DILLI 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3857 MAIN STREET, TRAPPE, MD 21673 JOHN T. BERRIER/HUSBAND Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ROSK CREEK CEMETERY 3-11-2004 WASHINGTON D.C. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME P.A. 200 S. HARRISON ST EASTON, MD 21601 JOHN MERLEROM 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Chronic obstructive bulmonary disoense **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner and I-transit Hospital or Attanding Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): the attending physician a Division of Vital Records, P.O. Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐ Pregnant at time of death 5 Other (specify) page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Whas an autopsy performed: 2 No certificate 1 Yes 1□ Yes 25. Was case referred to medical 26, Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient Certification: To 2 ER/Outpatient 3□ DOA 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) To the 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier Auchla MD D34974 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD, 601, South charles street, Baltimore, MD2, 230 CMARUNEHTA, 32 Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 0 5 2004 Registrar

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BEKLUEK,

State of Maryland / Department of Health and Mental Hygiene, 08688 Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month **Physician** MARCH 2004 2230 MARY LOUISE BALL /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Fecility Name (If not institution, give street end number) Examiner DENTON CAROLINE RUXTON HEALTH OF DENTON If Under 1 Year Months Days If Under 24 Hrs 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Day, Yeer) 5. Social Security Number 6. Sex Birthplece (State or Foreign Country) Funeral Hours 1 □ M 2 🗓 F 88 Director MAR 19 1915 MARYLAND 220-01-5976
Usuel Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. Stete 10b. County DENTON 1X Yes 2 □ No Funeral Director MD CAROLINE 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street end Number 21629 USA 420 COLONIAL DRIVE 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Maritel Status 1 ☐ Yes 2 X No If Yes, Give Yeer or Detes: 1 Never Married 2 Married 1 ☐ Yes 2K No Specify: Specify: WHITE Completed by 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) DAISY CUMMINGS HERMAN SCHARCH 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Relationship (Type, Print) 23158 DEER RUN CT. DENTON, MD 21629 JOAN D. SELLERS/DAUGHTER 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremetion 3 □ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) NEAVITT CEMETERY 3-8-2004 NEAVITT, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME P.A. 200 S. HARRISON ST EASTON, MD 21601 NOHN ₹. MERCERSA 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Jus mos la 2 days Examiner Due to (or es a consequence of) Physician/Medical Examiner use es tha buriel-trensit or Attending Physician: The law requires that the daeth cartificate be axecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as e consequence of): signed by tha at id be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Be Completed by 24b. Were autopsy findings Aftar this cartificeta hes bean s funaral director, paga 2 should 24a. Was an autopsy performed? available prior to completion of cause of death? within 24 hours aftar deeth.

To the Funeral Director: Aftar this cartificeta I complataly filled in by tha funaral director, pag 1 L Y 35 200 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: Surring Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medicai Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA 28e. Dete of Injury (Month, Dey Year) 27. Manner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Naturel 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 I Homicide 24 hours the Hospital 29a. Certifier rtifying Physiclen: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) end manner as steted. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. within 2 To the I 29c. License number 29d. Date signed (Month, Dey, Yeer) 29b. Signeture end title of certifit 037636 o completed cause of deeth (Item 23a) (Type, Print) 30. Name end eddress of person y ZIVP 1), 1) mak 7 31. Dete filed (Month, Day,

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State Registrar

Registrer's Signeture

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Physicia		- For F.D., TCHD, Registrer 1. Decedent's Name (First, Middle, Las Patricia Jeo	t)					2. Date of Death Month	Day	Year 1320 M
/Medica		4a. Facility Name (If not institution, give				4b. City, Town, o	r Location of Death	reonian	4c. County	
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Funeral Director		5. Social Security Number 6. Security 11 6. Securit		7. Age (In yrs. las	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 3 – 1 7 – 1	Year) 931	9. Birthplace (State or Foreign Country) Michigan
and and	ŀ	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Fown or Loc	cation				10d. Inside City Limits
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h the r 28a a routi	lrec	10e. Street and Number				10f. Zip Code	, , , , , , , , , , , , , , , , , , ,	10	g. Citizen of W	hat Country?
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re, Maryland 21215-0036 s.1 and 2 should be filed within 72 hours after death with the Maryla f Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-1 shouthar traumatic event. I'm Mudical Examinational De notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Deced Armed Ford 1 Tes 2 If Yes, Give Year or Dat	2₩ No	Ì	Vas Decedent of H Yes, specify Cuba	lispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Blac	a - American Indian, k, White, etc. : White
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Maryland 2121 d 2 should be filed within th and Mental Hygiene. 27 Is marked other than traumatic event. If a Mis	To Be	Leslie Jasper					Dorothy Dorothy	DuPre	У	9)
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Baltimore, sermit. Pages 1 a Department of Hec mportant: If Item any injury or othance.		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐	Removal from S	state cerr	etery, crem	sition (Name of natory or other place	ce)		Oc. Location -	City or Town, State
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Baltimore, permit. Pages 1 an Department of Heat Important: If Item 2 any injury or other once.		21. Signature of Funeral Service Licen		hu	D	Name and Addre	11 Hurle	y Fune	ral Ho	ome,PC.
		23a. Part1. Enter the disease, or compshock, or heart failure. List only	dications that ca	used the death.	Do not ente	or the mode of dying	ng, such as cardiac o	Michae r respiratory arre	ls,MD.	2166Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	M	yocar	dial	Info	rction			Onset and Death
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S, P	y PI	Part II. Other significant conditions of	ontributing to dea	ath but not resulti	ng in the ur	nderlying cause giv	ren in Part I.	23e. Did tob	acco use contr	ibute to the cause of death?
ords		Drosetes	melle	uhns				1 🗌 Ye	s 2□No	3 Probably 4 Unknown
ecc lawra as be	Completed	Hypert	in					24a. Was an autopsy	/ _ P	Vere autopsy findings available prior to completion of cause of
Vital Recipion: The lay certificate has rector, page 2	Con	Atrial	Fibbn	illah	n:			perform 1 Yes 2		eath? Yes 2 No
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Division of Vital Records, To the Hospital or Attanding Physician: The law requires the within 24 hours after death. To the Funaral Director: After this certificate has been signe completely filled in by the funeral director, page 2 should be completely filled.	Certification:	3 Suicide 6 Could not by determined	288. Place	of Injury - At hom ng, etc. (Specify)	e, farm, str	eet, factory, office		28f. Location (Str. City or Town,		er or Rural Route Number,
Divi	Medical (29a. Certifier 1 Certifying Ph (Check only one)	ysician: To the hiner: On the ba	isis of examinatio	edge, death n and/or inv	occurred at the til restigation, in my o	me, date and place, ppinion, death occurr	and due to the ca ed at the time, da	use(s) and ma ite and place, a	nner as stated. and due to the cause(s)
To the within. To the comple	Me	29b. Signature and title of certifier				29c. Licens		29		(Month, Day, Year)
		•					7067		2/26/	4
1		00.11	completed cause	e of death (Item 2	3a) (Type	Print)				
		30. Name and address of person who	rokede	6072	MITC	ilventi	LAME,	PASTON	I MD	21601

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08690 State of Maryland / Department of Health and Mental Hygiene 2 1 1 1 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Year March 2, 2004 Catherine Baker 10:05 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany County Nursing & Rehab Ctr. Cumberland Allegany 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

No Yrs Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 03/05/1915 9. Birthplace (State or Foreign Country) West Virginia 5. Social Security Number 6. Sex **Funeral** 1□ M 2ĂF 214-28-6851 Yrs Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Worls r than "neturel", or Items 23e or 28a-f shov the Wedical Evarth et must be notified at 1 ☐ Yes 2 No Director Allegany Cumberland 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? 15516 Baltimore Pike, N.E. 21502 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify: þ 3XXWidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 6 Clerk Retail permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked of the any injury or other treumatic event, 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Merritt Anna Lee Ritchie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeane A. Iames / daughter 15516 Baltimore Pike, NE., Cumberland, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State St. Luke's Cemetery 03/05/2004 Cumberland, MD ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Adams Family Funeral Nome. P.A. 404 Decatur Street, Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Vancreal Carcinonia Physician YVS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate the cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attended to the transmission of the completely filled in by the transmission. Due to (or as a consequence of): Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 DINO 25. Was case referred to medical examiner? 26. Place of Daath (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Other: 4 M Nursing Home 5 Residence 6 Other (Specify) 2 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27 Manner of Death 28d. Describe how injury occurred Certification: Natural 5 Pending investigation s after dea. 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier

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State Registrar 31. Date filed (Month, Day, Year) MAR 0 3 2004

30. Name and address of deson who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

Sunil K. Gupta, M.D., 32. Registrar's Signatury

625 Kent Avenue, Cumberland, MD 21502

29c. License number

D33280

29d. Date signed (Month, Day, Year)

March 3, 2004

			For State Registrar	Stat	e of Ma	ryland	d / Depa Cea	artmen rtificat	t of H e of L	ealth a Death	and M	lental Hy	/gieno) i ₄	0869	Militinapp
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			Shady Grove Ad						kvil	1e If Under	24 Hrs	0.0	-11-	Mont			
	Funeral		5. Social Security Number 186-07-9804	6. Sex 1 ☐ M 21⊠		(In yrs. Ia	st birthday) Yrs.	Months	Days	Hours	Min.	8. Date of Bi (Month, D Oct. 1	ay, Year,	015		lace (State or Foreig try) y land	gn
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an	fental fental rked ric ev	To Be	Jonas Martin							Fanr	nie N	Miller					
Maryland 21215-0036	and h		19a. Informant's Name/Relations	nip (Type, Prin.	t)		19b. Maili	ng Address	(Street a	and Numbe	or Run	I Route Numb	er, City	or Town, S	itate, Zip	Code)	
Σ.	and sealth m 27		Mary Markopoul	os (Da	ughte					Driv		Rockvil				. 24-4	_
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Baltimore,	nimer in Pa		* 4 □ Donation 5 □ Other (S _i 21. Signature of Funeral Service		. 1	Par	klawn					/1/04 /o1 Fun				Maryland	_
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Ć,	execu on and ial-tra	Еха	that initiated events resulting in death) Last	C	ue to (or as a	consequ	ence of):										
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9	entifica ling ph	Physician/Medical	IF FEMALE:	220 16 40	a cutooma c	·											
Вох	death certific e attending p ed for use as	lan/	23b. Was decedent pregnant in the past 12 months?	10	s, outcome d Live birth : 2 Pregnant at 1	2 Fetal	death 3]Ectopic pr						23d. Date Mont		ry Day Year	
o.	that the de led by the a detached t	ysic	1 □ Yes 2 2No 9 □ Unknown		Unknown			3 01.10. (90									
٥	law requires that the as been signed by th 2 should be detache	by PI	Part II. Other significant condition	ns contributing	g to death bu	t not resu	lting in the u	nderlying c	ause give	en in Part I.		23e. Did	tobacco	use contrib	oute to th	e cause of death?	
rds	n require been sig should b											1 🗆	Yes 2	□No 3	B ☐ Proba	ably 4 🖸 Unknow	m
Records,	has be ge 2 sho	Completed										24a. Was	psy	24b. W	ere autop	osy findings availab	le
<u>=</u>	T ate	Соп										perf 1 ☐ Yes	ormed? 2 🔯 No		ath? ⊒Yes	2 □ No	
Vital	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:			/		Othe)C		(Check only					_
o	Phys r this ral dir	T.	1 Yes 2 No 27. Manner of Death		1 Inpatier Date of Injury		PVOutpatier 28b. Time o		8c. Injury	4 🗀 Nu		me 5 Res 28d Describe				')	
lon	Attending Ph r death. ector: After th by the funeral	tlor	1 Natural 5 Pendin 2 Accident investig	g	(Month, Day	Yeer)	Injury	м		:? ∕es 2 🔲 I				•			
Division	l or Attencatter death Director:	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	ined 289.	Place of Inju			eet, factory	, office			28f. Location (or Rura	Route Number,	
	ital or irs afte ral Dir lled in																
	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	edical	29a. Certifier 1 Certifyin (Check only 2 Medical one)	g Physician: T Examiner: On and	To the best of the basis of manner star	examinati	vledge, deat on and/or in	h occurred vestigation	at the tim , in my op	e, date an pinion, dea	d place, th occurr	and due to the ed at the time,	cause(s date an	i) and mani d place, ar	ner as sta nd due to	ated. the cause(s)	
	To the within 2 To the comple	Me	29b. Signature and title of certifie	-				290	. License	number			29d. Da	ate signed	(Month, L	Day, Year)	
)	/_		1/4/	- W	3			1	146	35			02	127	120	004	
	53		30. Name and address of person	•				Print)						1 ,	1-		
			Dr. Michael Ce	tta 99				er Dr	ive,	Rock	cvil	Le, MD	2085	0			
	Sta Regist		31. Date filed (Month, Day, Year) MAR 0 1	2004	32. Registra	r's Signat	J J	10	aks								

			Please				. Ensure All			
			For State Registrar	State of Ma	ryland / Der Ce	partment of leartificate of	Health and Me Death		iene 00 L	08692
	Physici	an	1. Decedent's Name (First, Middle, La	st)			2	2. Date of Death Month	h Day Y <i>e</i> ar	3. Time of Death
	/Medic		Stephen	Arthur	Coffel	7		ebruar		
	Examin Funeral Director	er	4a. Facility Name (If not institution, given Shady Grove Advence Shady Shady Number Shady Shady Number 220–60–6356	ntist Hosp	ital o (In yrs. last birthda 51 Yrs.	Rockv	If Under 24 Hrs. 8 Hours Min.	3. Date of Birth (Month, Day,	4c. County of Dea Montgo Year) 9. Bir C	
	aryland ahow dall	_	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits 1★ Yes 2 \(\text{No} \)
	ith the Mi or 28a-f	Olrecto	Maryland Montgo 10e. Street and Number	mery	Gait	nersburg 10f. Zip Code		10	og. Citizen of What C	
	ath w	rai	419 Christopher A			2087			USA	
5-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or itema 23a or 28a-f ahow any injury ar-other traumatic event, the Madical Examiner must be notified at any injury ar-other traumatic event, the Madical Examiner must be notified at any injury.	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. Was Decedent If Armed Forces? 1 Yes 2 N If Yes, Give Year or Dates:		I. Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 ☑ No	Hispanic Origin? (Spec pan, Mexican, Puerto R Specify:	ify Yes or No- ican, etc.)	14. Race - Am Black, Whi	
õ	2 hou	ed	15. Decedent's E	ducation	16a. Dec	edent's Usual Occu	pation		16b. Kind of Business	
21215	l within 7; iene. r than "n. the Medi	Completed	(Specify only highest gr.	College (1-4or 5	+)	re kind of work done DO NOT use retire Manager	i during most of working ad)		Commerc:	
b	Hyg other	BeC	17. Father's Name (First, Middle, Last	")			18. Mother's Name (трритев
a	Med be	To B	Glen V	. Coff∈	lt.			Anna	Harvis	
Maryland	s ma		19a. Informant's Name/Relationship ((Type, Print)	19b. Ma	iling Address (Stree	t and Number or Rural	Route Number,	City or Town, State,	Zip Code)
Σ	and 2 salth n 27 i		Glen V. Coffelt/F	ather			Road, Rocky	ville, N	Maryland 2	0853
Baltimore,	ant of He nt: If iten		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Speci		cemetery, ca	position (Name of rematory or other pla	natory 2/29		20c. Location - City of	
Baltii	permit. P Departm Importar any inju		21 Signature of Funeral Service Lice	··	0	22. Name and Addre	ess of Facility DeVo eer Park Dr	1 Funer	al Home	
	-		23a. Part1. Enter the disease, or com	polications that caused	the death. Do not e					Approximate
	Physician /Medical		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each ling. a. Cardioge	enic Shock a consequence of):					Interval Between Onset and Death I hour
	Examiner	er	Sequentially list conditions, if any, leading to immediate	b Acute My		Infarctio	on			2 hours
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Coronary	Artery D	isease				3 years
,092	icate be executed physician and s the burial-transit	cai Exa	resulting in death) Last		a consequence of):	250000				July
687	certificate Iding phys Ise as the	edic								
.O. Box	the death y the atter iched for u	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	B □Ectopic pregnanc i □ Other (specify) _	cy .		23d. Date of de Month	livery Day Year
rds, P	Se Co	by	Part II. Other significent conditions	contributing to death be	ut not resulting in the	underlying cause gr	ven in Part I.		acco use contribute t s 2 □ No 3 □ P	o the cause of death?
Vital Records,	e law has b je 2 st	Completed						24a. Was ar autopsy perform 1 Yes 2	ned? death?	utopsy findings available comptetion of cause of
ita	sician: Th certificate rector, pag	Be C	25. Was case referred to medical				26. Place of Death			
of V	4 % P	To	examiner? 1 ☐ Yes 2🏋 No	Hospital: 1 🖾 Inpatie	nt 2 ER/Outpat	ent 3 DOA	her: 4 🗌 Nursing Hom	e 5 Reside	nce 6 Other (Spe	ecify)
ion o	ding h. After fune		27. Manner of Death 1 XNatural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Date	y Year) 28b. Time Injury	Wo	rry at 28 ork?] Yes 2 □ No	d. Describe ho	w injury occurred	
Division	in Site	Certification:	3 Suicide 6 Could not t 4 Homicide determined		ury - At home, farm, c. (Specify)	street, factory, office	28	3f. Location (Str City or Town	reet and Number or A , State)	ural Route Number,
	To the Hospital within 24 hours a To the Funeral Completely filled	edicai	29a. Certifier 1½ Certifying P (Check only 2 ☐ Medical Exa	hysician: To the best miner: On the basis of and manner sta	examination and/or	ath occurred at the t investigation, in my	ime, date and place, an opinion, death occurred	nd due to the ca	use(s) and manner a ate and place, and du	s stated. e to the cause(s)
	within To th	Σ	29b. Signature and title of certifier	- N	7	29c. Licen	se number	25	d. Date signed (Mon	th, Day, Year)
	12		Mobert 7	Coll	- un	D 29	300	F	ebruary 28	3, 2004
	1		30. Name and address of person who						-	
			Robert L. Gold, 1 31. Date filed (Month, Day, Year) MAR 0 1 2	M.D.,15225	Shady Gro	ve Road,#	201, Rocky	ille, M	D. 20850	
	Sta Regist	ate rar	MAR 0 1 2	004 Sens	ar a Signature	Spark	2			

DHMH 17 Rev 1/2001

08693 State of Maryland / Department of Health and Mental Hygien [] [] Certificate of Death 3. Time of Death 2. Date of Death 1, Decedent's Name (First, Middle, Last) Month Year **Physician** 7:10 p^M Lacina Cisse Feb 29 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Rockville Casey House Hospice If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex 5. Social Security Number **Funeral** 1 ☑ M 2 ☐ F 218-15-4766 Feb. 27, 1964 Ivory 40 Coast Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City. Town or Location is 1 and 2 should be filed within 72 hours after death with the Marylan of Heelih and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Example at munit by notified at 10a, State 10b. County 1√2Yes 2 No Funeral Director Montgomery Gaithersburg Md. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20877 U.S.A. 5 Spring St. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, While, etc. 1 ☐ Yes 2 No 1 ☐ Never Married 2 X Married Black Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Ritz Carlton Engineer 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Sylla Matogoma Bamoussa Cisse 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Heelth and Important: If Item 27 is n any injury or other traun Aminata Kone/wife Spring Street, Gaithersburg, Md. 20877 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Slate 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Adelphi,Md. George Wash.Cemetl. 3/5/04 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Universal II Mortuary Inc. 21. Signature o Funeral Service Licensee 411 Kennedy St, N.W., Wash, D.C. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metastatic Large B-cell lymphoma 1yr **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4☐Pregnanl at time of death 9☐ Unknown Month Day Year 5 Other (specify) 1 ☐ Yes 2 🛛 No P.O. ed by the detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Acquired Immunodeficiency Syndrome 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s as 1 ☐ Yes 2 ☐ No certificate 1 Yes 2 X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 MOther (Specify) HOSDIC 8 Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA 2 1 ☐ Yes 2 X No After this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28h. Time of 28d. Describe how injury occurred To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death Certification: 5 Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, elc. (Specify) 4 Homicide 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title 2/ who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person Charles Harrison 6001 Mill Rd. Rockville, Md 20855 Muncaster 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 05 renew 2004

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Jin Cang Cen February 26, 2004 рм 4:31 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Mariner Health- Bethesda Bethesda Montgomery 7. Age (In yrs. last birthday) If Under 1 Year II Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🙀 F Yrs Director 212-96-6230 99 Sept. 29, 1904 China Usuel Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Maryland | Montgomery Wheaton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with or Items 23s or 2800 Blueridge Avenue 20902 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11, Marital Status filed within 72 hours after ☐Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 by If Yes, Give Year or Dates: 1 Yes 2 No Specify: Specify: Asian 3 Widowed 4 □ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h. Kind of Business/Industry then Elementary/Secondary (0-12) College (1-4or 5+) Farmer None Agriculture other other traumatic event, 17. Father's Name (First, Middle, Last) mit. Pages 1 and 2 should be file partment of Heelth and Mental Hy portant: If item 27 is marked oth y injury or other traumatic event ce. 18. Mother's Name (First, Middle, Maiden Sumame) Be Kim Sim Ching Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward Chin / Grandson 13003 North Commons Way, Rockville, MD 20854 20b. Place of Disposition (Name of cemetery, crematory or other place)
Fort Lincoln
Cemetery 20a. Method of Disposition March 2 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) 2004 Brentwood, Maryland 21. Signature of Funeral S 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part1. Enfor the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Congestive Cardiomyopathy /Medical Due to (or as a consequence of): Examiner Cerebrovascular Accident Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated assets. Due to (or as a consequence or) Examiner or Attending Physician: The law requires that the death certificate be executed the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): physicien Box 68760 Physician/Medical use as t IE FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year 4☐Pregnant at time of death Day 5 Other (specify) Division of Vital Records, P.O. 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2X No. 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Certification: To Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2€No 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After iXXNatural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident the Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by within 24 hours after or To the Funerel Direct completely filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Dan D27660 February 27, 2004 30. Name and address of person wing completed cause of death (Item 23a) (Type, Print) Alpana Goswami M.D. 31. Date filed (Month, Day, Year) 11119 Rockville Pike, Rockville, MD 20852 32. Registrar's Signature State MAR 01 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien) 1 08695 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month Physician Shu Chan February 23, 2004 11:45 Α /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Holy Cross Nursing & Rehab Burtonsville Montgomery If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** 1 ☐ M 2 🔀 F 89 Sept. 10, 1914 China Director 219-92-7695 Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City. Town or Location 10a. State 10b. County iral', or Itams 23a or 28a-f show Examiner must be notified at 1√2 Yes 2 □ No Maryland Montgomery Burtonsville Direct 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number 3415 Greencastle Rd. China 20866 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after Health and Mental Hygiene. 1 Never Married 2 Married 1 Yes 27 No Baltimore, Maryland 21215-0036 1 ☐ Yes 3(T)No Specify: Asian þ 3 ₩idowed 4 Divorced Year or Dates "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Medical than Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 8th other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Is marked Unobtainable Unobtainable 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is any injury ocother trans 14729 Silverstone St. Silver Spring, MD 20905 Carrie Chin- Daughter Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 02/27/2004 Silver Spring, MD Gate of Heaven Cem. * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilitHines-Rinaldi Funeral Home 21. Signature of Funeral Service Licensee 11800 New Hampshire Ave. Silver Spring, MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 7 Days **Physician** Pneumonia /Medical Due to (or as a consequence of): Examiner 6 Yrs Cerebral Vascular Accident Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Many Yrs Hypertension burial-tran Due to (or as a consequence of): been signed by the attending physician should be detached for use as the burial Division of Vital Records, P.O. Box 68760, Physician/Medical IE FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Day Year Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Senile dementia, chronic renal insufficiency Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an anemia autopsy page 2 certificate 1 Yes 2√ No Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 w Nursing Home 5 Pesidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 ☐ Yes 2 ☐ XNo this 28a. Date of Injury (Month, Day Year) neral Cirector: After the 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death or Attending Injury 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 3 🗌 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2] Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier

State Registrar

completely

the

2

31. Date filed (Month, Day, Year) 2004

Feiton

(Check only one)

8630

29b. Signature and title of certifier

Street 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Silver SIL

29c. License number

29d. Date signed (Month, Day, Year)

Bernadtte

			1 — For State Registrar	State	of Marylar	nd / Depa <i>Ce</i> a	artment o	of He	ealth a <i>Peath</i>	ind M		giene2 ()	04	08696
	Physici /Medic		Decedent's Name (First, Middle,		n CAIN						2. Date of Dea Month March 3	Day	Year	3. Time of Death
× .	Examir		4a. Facility Name (If not institution, 9 641 Lake Varuna		imber)		4b. City, To Gait!				1012 011 3	4c. County	of Death	
	Funeral Director		113-40-3683	.Sex 1 □ M 21/2] F	7. Age (In yrs.	last birthday) 39 Yrs.		Year Days	If Under 2 Hours	Min.	8. Date of Birt (Month, Day Jan . 29	h y, Year)	Cou	place (State or Foreign ntry) York
	Aaryland I show	ō	Usual Residence of Decedent 10a. State 10b. County Maryland Mont	gomery	10c. Ci	ty, Town or Lo	cation thersb	1 r 0						10d. Inside City Limits
	with the h la or 28a-i Lby notifit	Direct	10e. Street and Number 641 Lake Varuna			Gar	10f. Zip Co		208	 78		10g. Citizen of United		ntry?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-1 show may injury or other treumatic event, the Marked Examinar round be notified at once.	by Funera	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	Armed F	2 No		Was Decedent If Yes, specify		panic Orig , Mexican, Specify:	in? (Spec , Puerto F	cify Yes or No- Rican, etc.)		ce - Americk, White,	
Maryland 21215-0036	swithin 72 hou plene. I then "neture The Musical E	ompleted	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	grade completed)	1-4or 5+)	(Give	dent's Usual C kind of work of DO NOT use i cal Ass	done du retired)	ring most	of workin		16b. Kind of B		
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altimore,	Pages 1 ment of Hu ant: If iter		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	cify)	State	Place of Dispo cemetery, crer den of	natory or othe	r place)	1		/ 04	20c. Location -	,	
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	Physician /Medical		23a. Party Enter the disease, or conshock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	a. ME	caused the deaf each line. TASTA (or as a consec	nc	BIZEA			ardiac or		34		Approximate Interval Between Onset and Death 5 MoS
8760,	zate be executed by sician and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	c	(or as a conseq									
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rds, P.	v requires that the de been signed by the should be detached		Part II. Other significant conditions	s contributing to a	leath but not res	sulting in the u	nderlying caus	se given	in Part I.		23e. Did to			ne cause of death?
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Division of Vit	ng Phys Iter this Ineral di	ation: To Be	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigat	28a. Date (Mon	Inpatient 2 of Injury th, Day Year)	ER/Outpatien 28b. Time of Injury	-	Other: Injury a Work?	4 □ Nurs	sing Hom		ence 6 □Othe ow injury occurr		<i>(</i>)
Divis	tal or Attences after death	Certification:	3 ☐ Suicide 6 ☐ Could not determine	280. Place	e of Injury - At hi ling, etc. <i>(Specil</i>	ome, farm, str	eet, factory, of	ffice		28	8f. Location (Si City or Town	treet and Numb n, State)	er or Rura	l Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fo	Medical	one) 2 Medical Ex	Physicien: To the eminer: On the band man	e best of my kno easis of examina ner stated.	owledge, death ation and/or inv	estigation, in	my opir	nion, death	place, ar occurred	nd due to the c d at the time, d	ause(s) and ma late and place, a	nner as st and due to	ated. the cause(s)
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State of Maryland / Department of Health and Mental Hygiene 2001.

				State of Mar	ryland	l / Depart <i>Certi</i>	tment of life	lealth and Death	Mental Hy	rgiene 20	0 L	086	597
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'n	/Medic Examin		4a Fecility Neme (If not institution, give					4b. City, Town, or	Locetion of Deat	h 4c. County o	of Death		
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	Funeral Director		212-12-9025	x 7. Age (M 2□ F	(In yrs. las 97		If Under 1 Year Months Days			av. Year)	9. Birthpla Count Ita.	ace (State o by) Ly	r Foreign
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	the A	E C	Maryland Anne Aru	IIGEI	711111	фотть	10f. Zip Code			10g. Citizen of W	hat Count	nv?	
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	ems 2	Funeral Director	11. Merital Status	12. Wes Decedent Ev Armed Forces?	er in U,S.	. 13. Wa	s Decedent of I	Hispenic Origin? (S ean, Mexican, Puer	specify Yes or No to Rican, etc.)	- 14. Race Black	- America		
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<u>ē</u>	- I 5 5	1	John Ciccarone/ So 20a. Method of Disposition		20b. Plac	ce of Dispositi			Date	20c. Location - C		n, State	
aitimore,	Pages nent of int: If its iry or o	Н	1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)		1		Cemete		March 3	2004 An	napo	lis. N	/ID
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		\dashv	23a. Pert1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused th	ne death.							Approximate	В
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	/Medical Examiner		Immediate Cause (Final disease or condition	. H	URE	erten	Sim					المات	400
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X Q Q	death certifi e attending ed for use es	2		1	الحق	Johnson	Q Vos	see us	is ease	•	<u>i</u>		
מ	death	sicia	Part II. Other significant conditions cor	ntributing to death but	not resulti	ing in the unde	orlying cause giv	ven in Pert I.	23b. Did	tobacco use cont	tribute to	the cause o	of death?
7. O	v requires that the de been signed by the s should be deteched	Physician/M	W. C.						1 🗆	Yes 2□ No	3 ☐ Probe	ably 4 Da	Unknown
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5		o Be	avaminar?	lospital:	2□ =	R/Outpatient	3 DOA Oth		ath (Check only	o <i>ne)</i> dence 6 □Other	(Specify)		
0	문 등 교	$\vdash \parallel$	27. Menner of Death	28a. Date of Injury	2	8b. Time of	28c. Inju			how injury occurre			
0	Attanding For death. actor: After by the funer	atle	1 Matural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Y	(667)	Injury		Yes 2□No					
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	o the	ž Z	29b. Signature and title of certifier	A manifer side			29c. Licens	se number		29d. Date signed	(Month, D	ay, Yeer)	
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		-	30. Name end eddress of person who co	ompleted cause of dee	th (Item 2	3e) (Type, Pri	nt)						
			Ming M. Nusci		m	ADISON A	nork,	Suite 100,	6/en 130	coie, ma	576	ad.	
	Sta Begistr		31. Date filed (Month, Day, Year)	32. Registrer's	s Signatui	K L							

State of Maryland / Department of Health and Mental Hygiene 2 1 1 08698 Certificate of Death 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 28, CALDWELL, SR. P^{M} February 2004 2:56 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 6. Sex 1 M 2 □ F 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. Yrs. 524-07-9660 78 1926 Feb. Colorado **Director** Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. Count ? is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Maxical Examinate must be notified at 1X Yes 2 No Directo Maryland Prince Georges Bowie 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 15900 Pennant Lane 20716 U.S.A. Funeral death 14. Race - American Indian. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 Never Married 2 Married 1944-Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black Completed by 3 ☐ Widowed 4 ☐ Divorced 1947 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Peace College (1-4or 5+) Elementary/Secondary (0-12) Director Corps 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fill ment of Health and Mental Heart: If item 27 is marked officiary or other traumatic even Franklin Caldwell Odessa Lillian McCullough Leonard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15900 Pennant Lane, Bowie, Maryland 20716 Ruth Caldwell/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any Injury or once. Cedar Hill Cemetery 3/6/2004 Suitland, Maryland ^ 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service Licensee 16000 Annapolis Road, Bowie, Maryland 20715 Men 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sobsis Physician ows disease or condition resulting in death) /Medical Due to (or as a consequence of): clostridial colitis Wee RS Examiner ulcerative and Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 Other (specify) ed by the a detached f 1 Ves 2 No 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by ed bluods 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has page 2 certificate 1 ☐ Yes 2 ☑ No ral director. 25. Was case referred to medical Certification: To Be 26. Place of Death (Check only one) Hospital: 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: All completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2-28-2004 1 57078 30. Name, and address of person who completed cause of death (Item 23a) (Type, Print) 144 Medical arkway, Sunapolis Jacqueline 2201 31. Date filed (Month, Day, Year) 32. Paistrar's Signature State MAR 0 1 2004 Registrar

			1 - For State Registrar 1. Decedent's Name (First, Middle, Last,	State of Ma	rylanı		artment of h			-	Reg. No	00	04	0.8 3. Time of	<u>699</u>
	Physici /Medic	al	Joan Elizabeth (Cullens			4b. City, Town, o	or Location	of Death	Feb.	29	County of	OO4	6:05	
	Examin Funeral	er	489 Broadwater Re 5. Social Security Number 6. Sec	oad x 7. Age		ast birthday)	•	nold	24 Hrs.	8. Date of Bir (Month, Da	th	Ann	e Ar	undel	_
	Director		219-76-4777 Usual Residence of Decedent 10a. State 10b. County	□ M 21 3 (F	78 10c. City	Yrs.				Jan. 7	, 19	26 l		Scoti	
	ith the Mary or 28e-f sh	Director	MD Anne Ar	1			Arno				10g. Cit	izen of Wh		1 □ Yes	2 ∑ No
336	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or Items 23e or 28e-f show entry injury or other treumetic event, I'm Medical Examinar must be notified at once.	by Funeral I	489 Broadwater Ro 11. Marital Status 1 □ Never Married 2 ★ Married 3 □ Widowed 4 □ Divorced	Dad 12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:			Was Decedent of H f Yes, specify Cub		igin? (Spe n, Puerto f	cify Yes or No Rican, etc.))-	14. Race -	White, e		
Baltimore, Maryland 21215-0036	I within 72 houiene iene "nature r then "nature the Medicul E	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		+)	(Give	lent's Usual Occup kind of work done OO NOT use retire HOME	during mos		ng	16b. K	ind of Busi		ustry	
yland 2	2 should be filed withir and Mental Hygiene. is marked other then eumetic event, the M	To Be C	17. Father's Name (First, Middle, Last) Thomas H. Boudre					Bea	trice	(First, Middle, e O'Nei	.11	Sumame)			
re, Mar	Tand 2 sh Health and tem 27 is m		John W. Cullens/1 20a. Method of Disposition		20b. P	489 E	g Address (Street Broadwate sition (Name of	er Roa	id, Ai	rnold,	MD	2101. 2101. ocation - Ci	2		
altimo	permit. Pages Department of i Importent: If its eny injury or o'		1 Burial 2 XCremation 3 F 4 Donation 5 Other (Specify) 21. Signature of Purpla Service Licens			tro Cr	natory or other pla cematory Name and Addre Sarranco		Mar. 200	04		ltimo:			Home
8760,	Icate be executed physician and the burial-transit physician and sthe burial-transit physician and the	dicai Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ne cause on each line	e. Cas consequ	ience of):	an(eV	19, 30011 23	oardiao di	теариасту а	11631,			Approximate Interval Betv Onset and D	veen Death
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ō	Phys or this oral di	. To	27. Manner of Death	28a. Date of Injun		28b. Time of	t J DOX	4 🗆 140	-	ne 5 K Resident 8d. Describe I					-
Division of Vital Records,	To the Hospitel or Attending Physicien: The within 24 hours after death. To the Funerel Director: After this certificate h completely filled in by the funeral director, page	Certification:	Tatural 5 Pending investigation 3 Suicide 6 Could not be determined	(Month, Day 28e. Place of Inju- building, etc.	ry - At ho	Injury me, farm, stre	M 1□	rk? Yes 2. □	-	8f. Location (S City or Tox			or Rural	Route Numl	ber,
	To the Hospitel within 24 hours a To the Funeral completely filled	Medical C	(Check only 2 Medice! Exemi	sicien: To the best o ner: On the basis of and manner stat	examinat	wledge, death ion and/or inv	estigation, in my o	ppinion, dea	nd place, a oth occurre	d at the time,	date and	place, an	d due to	the cause(s)	
	To the within 1	2		reins,			29c. Licens DS Print) #350	283	30		MG. Dat	e signed (L Zo	ay, rear)	
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	Registr		MAR 0.2	2004	2	M	North .								

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2001 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Yeer February 29, 2004 **Physician** Charlotte H. Consentine 11:27 A^M /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Deeth 4b. City, Town, or Location of Death Examiner Anne Arundel Medical Center Anne Arundel Annapolis 8. Date of Birth (Month, Day, Year) Sept. 13, 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex Birthplece (State or Foreign Country) **Funeral** Months Days Hours Min 1 □ M 2804F Yrs. 1925 78 Virginia Director 218-22-7929 Usuel Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. Count r then "naturel", or items 23e or 28a-f ehow the Medical Examinar mail be multiped at Anne Arundel Annapolis Maryland 1√2 Yes 2 No Funeral Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21403 200 Washington Street U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No White Specify: δ 3€Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Waitress Restaurant 12 other 7 is marked othe traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event Be Raymond Copenhaver Else Creger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Copenhaver/brother 101 West Walnut Street Northeast, MD 21901 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans Cem. 3/5/2004 Crownsville, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fire al Serve Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD 21401 Media 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** PSUS /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Physician/Medical Examiner anding physician and use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) IF FFMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 Ho
9 Unknown jo Day 5 Other (specify) 9 Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ို 1 m atient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Yeer) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

P.O. Box 68760. Division of Vital Records.

Medical Certification: Japital ...
4 hours after dea...
-ral Director: After 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral C

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 5 3 completed cause of death (Item 23a) (Type, Print) 30. Name and address of person 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 0 3 Registrar 2004 DHMH 17 Rev 1/2001 **ORIGINAL**

To the

State of Maryland / Department of Health and Mental Hygiene 2004 For State Registrar 08701 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 28 3. Time of Death **Physician** Samuel Creek February 2004 6:50P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Millennium @ South River Edgewater Anne Arunde1 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day. Hours Min. Dec. 20. 5. Social Security Number 6. Sex **Funeral** 7. Age (In yrs. last birthday) 9. Birthplece (State or Foreign 1932 Maryland DXDMM 2□ F 71 Director 219-30-5803 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow d other then "natural", or Itams 23s or 28s-f shovevent, the Medical Examiner must be notified at Directo Maryland Anne Arundel 1 ☐ Yes 2 ☐ No Churchton the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death a Department of Health and Mental Hygiene. Important: If Hem 27 is marked other then "netural", or Items 22-eny injury or other traumatic event, the table by Funeral 5425 Deale Churchton Road 20733 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: **Black** 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coltege (1-4or 5+) Lisbon Maderia 6th Laborer Construction Co 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ٩ Arthur Creek Elsie Gray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald Gross (Son) 1152 Gwynne Ave. Churchton, Md. 20733 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Union U.M. Church 1 Burial 2 □ Cremation 3 □ Removal from State *4 ☐ Donation 5 ☐ Other (Specify) Cemetery 3
22. Name and Address of Facility 3/5/04 McKendree, Md 21. Signature of Funeral Service Licensee Z Name and Address of Facility
Wm. Reese & Sons Mortuary, P.A.
Apparolis, Md. 21401 Larry D. Reese M00483 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cerchydour **Physician** akripschon /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de 23b. Was decedent pregnant 23d. Date of delivery ned by the attent 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death Month Day Year 5 Other (specify) o 9 Unknown ۵. signed l Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably s certificate has t 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? of Vital 1 Yes 2 No To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☐ No Other: Certification: To Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Alatural 5 Pending М investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 132136 30. Name and address of person who completed cause of death (Item 23a) (Type, Print). Donot Mine Charles Wo 2/6/9 w 7118 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar MAR 0 4 2004

State of Maryland / Department of Health and Mental Hygiene 2004 08702 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 3 **Physician** March 2004 Christina Joyce Cooper 5:05 A^{M} /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 13980 Dulin Road Oueen Anne Talbot 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 29, 1930 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 1 □ M 2 12 F 524-36-3645 73 Michigan Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 28a-f show r than "natural", or Itama 23a or 28a-f ahov the Medical Examiner must be notified at Talbot Maryland Oueen Anne 1 ☐ Yes 2 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10 13980 Dulin Road 21657 U.S.A. Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes २००० If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes > No Specify: White Specify: þ 3X3√Vidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) State Government Elementary/Secondary (0-12) College (1-4or 5+) nd Mental Hygiene. marked other than Financial Account Supervisor 2 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If item 27 is marked o Donald E. Pullen Ruth Anna Selby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Cooper/son 13980 Dulin Road Queen Anne, MD 21657 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Ottor (Specify) injury o Baltimore Crematory 3/5/2004 Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home once 'n 1 147 Duke of Gloucester St. Annapolis, MD 21401 rt1. m And 1. The disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hand failure. List only one cause on each line. Approximate Interval Betw Onset and Death Immediate Cause (Final disease or condition resulting in death) Autoimmune Hepatitis Physician /Medical Due to (or as a consequence of) Examiner Coagulopathy Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner death certificate be executed **burial-transit** Pancytopenia and that initiated events resulting in death) Last Due to (or as a consequence of). the attending physicien Division of Vital Records, P.O. Box 68760, Physician/Medical as the IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? Day Year 5 Other (specify) Yes 2X No detached 9 Unknown The law requires that the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à aq 1 Yes 3 Probably 4 Unknown 2×3×10 Completed been s 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? certificate 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2€XNo 2 ER/Outpatient 3□ DOA this 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred After Certification: 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 🔀 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one within 2 the 29c. License number 29b. Signature and 29d. Date signed (Month, Dey, Year) 2 D 0052783 March 3, 2004 30. Name and address of person pleted cause of death (Item 23a) (Type, Print) Dr. Cynthia Huffaker 205 Ridgely Avenue Annapolis, MD 21401 31. Date filed (Month AR 32. Begistrar's Signature State 2004 Registrar

DHMH 17 Rev 1/2001

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State Registrar

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State of Maryland / Der

partment of Health and Ment	ai Hygiene) n n i.	0 0	71
ertificate of Death	2004	U D	11

16 Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 26, **Physician** ELIZABETH FEBRUARY LEESTA CHILCOTT 2004 7:50 A.M. /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner CUMBERLAND NURSING HOME CUMBERLAND ALLEGANY 8. Date of Birth (Month, Day, Year) NOV • 27,1914 If Under 1 Year 5. Social Security Number If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Months Days Hours 1 □ M 2X F 89 214-07-6823 Director MARYLAND Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "neturel", or items 23e or 28e-f show traumatic event, the Madical Examinar must be notified at MD ALLEGANY CUMBERLAND 1XYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10 N. LEE STREET 21502 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 🎖 ☐ No Specify: à Specify. 3 ☐ Widowed 4 ☐ Divorced WHITE Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) OFFICER-MANAGER INSURANCE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 end 2 should be nent of Health and Mental MINNIE J. CECIL HARRY L. CHILCOTT ္ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If itam 27 Is PATRICIA LEWIS / NIECE 120 W. 97th. STREET, NEW YORK, NY 10025 Injury or other 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State HILLCREST BURIAL PARK 03/06/2004 CUMBERLAND, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral S-rvice Licenses Neme and Address of Facility UPCHURCH FUNERAL HOM E, P.A. 202 GREENE STREET, CUMBERLAND, MD 21502 23a. Part1. Enter the disease, or comshock, or heartfailure. List only complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Intervel Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Examiner or Attanding Physician: The law requires that the death certificate be executed attending physician and I for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of) resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the ceuse of deeth? the th deteched signed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown þ æ Completed 24b. Were eutopsy findings evailable prior to completion of cause of death? 24a. Was en autopsy performed? hes page certificate 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 🗆 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 SNatural 2 ☐ Accident 5 Pending after death.

Diractor: Aff
d in by the fur 1 TYes 2 □ No investigation 6 Could not be determined To the Hospital or Atta within 24 hours after der To tha Funeral Directo completely filled in by the 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nds PE 1 ER (4 MA 02 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 0 3 2004 Registrar

DHMH 16 Rev 6/95

			1 - For State Registrar AMEND#4 apent		-		artment of H		d Mental Hy	giene	2004	08705
	Physici /Medic		1. Decedent's Name (First, Middle,		D	,16.	e (9		2. Date of De Month	Day	2004	3. Time of Death
	Examir		2604 8/2	ora 57		ast birthday)	4b. City, Town, or Che If Under 1 Year	If Under 24	Hrs. 8. Date of Bir	m	9. Birthpl	mery ece (State or Foreign
	Funeral Director		577-56-9856 Usual Residence of Decedent	1□M 2∏xF	80	Yrs.	Months Days	Hours	Min. (Month, De Aug. 1	192.		York
	the Marylan 28a-f show colified at	ector	10a. State 10b. County Maryland Montg 10e. Street and Number	omery		r, Town or Lo				10a Citize	en of What Coun	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
	23a or	Funeral Director	2604 Elnora St	reet			20902				USA	
036	s within 72 hours after death with the Maryland Jene. r than "natural", or Itams 23a or 28a-1 show the Mayloal Examiner roust be mailled at	þ	11. Marital Status 1 □ Never Married 2 □ Marrie 3 □ Widowed 4 ☒ Divorced	12. Was Decedent Armed Forces? d 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	,		Was Decedent of Hi If Yes, specify Cuba 1 □ Yes 2 ☒ No	ispanic Origin n, Mexican, P Specify:	? (Specify Yes or No Puerto Rican, etc.)		4. Race - America Black, White, e Specify: Whit	etc.
21215-0036	within 72 ene. than "na	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)		5+)	(Give lite.	dent's Usual Occupa kind of work done o DO NOT use retired nemaker	during most of	f working		d of Business/Ind	ustry
Maryland 2	be file tal Hyg d othe	To Be Co	17. Father's Name (First, Middle, L. Abraham Landar			1101			Name (First, Middle	Maiden S		
Mary	and and is m		19a. Informant's Name/Relationshi	, ,, ,					or Rural Route Numb ew Carroll			
Baltimore,	Pages 1 and in the lent of Health nt: If Item 27.		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 4 ☐ Donation 5 ☐ Other (Special Control Contr	B □Removal from State	Ce	ace of Dispo emetery, crei	sition (Name of matory or other place	e) Fe	bruary 27 2004	20c. Loca	ation - City or To	
Balti	permit. Pages 1 Department of H Important: if Ite any injury or ot once.		21. Signature of Funeral Service Li	tes		F: 50	Name and Address rancis J. 00 Univer	s of Facility Colling Sity B.	ns Funeral 1vd. W., S	Home Home	e Inc.	MD 20901
中原产品人。	Physician /Medical Examiner		23a. Part1. Enter the disease, or c shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as	C	VD	er the mode of dying	g, such as car	rdiac or respiratory a	rrest,	Dn	Approximate Interval Between Onset and Death
68760,	ate be executed hysician and the burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as c. Due to (or as d.								
.O. Box 68	death certific e attending p od for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal	death 3	Ectopic pregnancy Other (specify)			23	Bd. Date of deliver Month	y Day Year
s, P	law requires that the as been signed by th 2 should be detache	þ	Part II. Other significant condition	s contributing to death b	out not resu	ilting in the u	nderlying cause give	en in Part I.	100000			cause of death?
I Record	The la ate has page 2	Completed							24a. Was autop pento 1 ☐ Yes		prior to com death?	sy findings available indicate of 2 No
f Vital	Physicien: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 → Yes 2 □ No	Hospital: 1 ☐ Inpatie	ent 2 🗆 E	ER/Outpatier	it 3□ DOA Othe	NP:	Death (Check only only only only only only only only		☐Other (Specify,)
Division of	ding h. After fune	Certification;	27. Manner of Death Natural Accident Suicide 2 Accident Suicide 6 Could no	t be	y Year)	28b. Time o Injury	M 1 🗆 Y	rat k? Yes 2 □ No	28d. Describe			
Divi		Certifi	4 Homicide determin		jury - At ho tc. <i>(Specify</i>	me, farm, str	eet, factory, office		28f. Location (City or Tox		Number or Rural	Route Number,
	To the Hospitel or Attenwithin 24 hours after deat To the Funerel Director: completely filled in by the	ledical	(Check only one) 2 Medical E	Physician: To the best kaminer: On the basis of and manner st	of examinat		vestigation, in my or	oinion, death o		date and p	place, and due to	the cause(s)
)	V V V	M	29b. Signature and title of certifier	spelim	o o	ME	D O	042	8	Sel	signed (Month, D	2004
	•		30. Name and address of person w 12 R ~ BR 31. Date filed (Month, Day, Year)	ho completed cause of c	death (Item	23a) (Туре, От Е	Print) 2101 Silv	er 5	ucal P	mp	Dr 209	02
4.	Sta Registi		31. Date filed (Month, Day, Year) MAR 0 1	32. 9egistr	rar's Signat	ure &	Sparks	/ /)			

State of Maryland / Department of Health and Mental Hygiene 2004 08706 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 6:45 P M February 28, 2004 Samuel Dubin /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Montgomery General Hospital 01ney
If Under 1 Year | If Under 24 Hrs. Birthptace (State or Foreign Country) 6. Sex . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 M 2 □ F Yrs Director 076-22-9956 June 17, 1929 New York Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location rithan "natural", or iteme 23a or 28a-f ahow the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Silver Spring Marvland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 3172 Adderly Court Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status filed within 72 hours after 1 ☑ Yes 2 ☐ No 1962—
If Yes, Give
Year or Dates: 1967 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 ☐ Widowed 4 St Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ind 2 should be filed within 7 alth and Mental Hygiene.
27 is marked other than *r ir traumatic event, the Med College (1-4or 5+) Elementary/Secondary (0-12) 5+ Psychiatrist Mental Health 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: if tiem 27 is marked eny injury or other traumatic events. Morris David Dubin Rose Gurtler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward John Dubin/ Son 12505 Waldo Lane, Silver Spring, MD 20904 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State March 4, 2004 MD Veteran's Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Crownsville, Maryland 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licenses Tru 500 University Blvd. W., Silver Spring. MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician Sepsis 48 hours disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner death certificate be executed and -tran Due to (or as a consequence of) s the burial-Box 68760. as IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year jo 4☐Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown 2 signed t 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, by 99 1 Yes 2 No 3 Probably 4 Unknown certificate has been si rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? page 1 Yes : After this certifica e funeral director, r 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဥ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Division Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t determined 4 - Homicide To the Hospitel f Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier lerestoph 039793 February 29, 20 ways, Mis. 10+ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Philip Se. #328 1814 Prince Olnay Christopher J. Mays, mo 31. Date filed (Month, Day, Year) MAR 0 5 32. Registrar's Signature State Lyane oaks

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 For State Registrar 08707 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** February 25, 2004 0527 a Mary Martha Davis Demick /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 01ney
If Under 1 Year
Months Days Montgomery Montgomery General Hospital If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Min. Hours 1 □ M 2 🖸 F Yrs. Aug. 15, 1959 Director 214-76-1751 Virginia Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County *how r than "natural", or Itams 23a or 28a-f shov the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Directo Silver Spring Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number **USA** 1908 Brightleaf Court 20902 death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Peges 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itas any injury or other traumatic avent, the Medical Examinas ones. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: Specify δ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u>Analyst</u> Federal Government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 2 Leeland Davis Ann Marie Armstrong 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1908 Brightleaf Court Silver Spring, Maryland 20902 Michael Demick Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Metropolitan
Crematory 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Feb.28,2004 Alexandria, Virginia 22. Name and Address of Facility 21. Signature of Funeral Service Licenses 20901 Francis J. Collins Funeral Home, Inc. 23a. Part 1. Enter the disease, or complications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** a Cardiac Arrhythmia day resulting in death) /Medical Due to (or as e consequence of): **Examiner** 20 years b. Chronic Renal Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner the attending physicien and thed for use as the burial-transit Hospitel or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) ☐Yes 2 No detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. þ 99 1 ☐ Yes 2 😾 No 3 Probably 4 Unknown Rheumatoid Arthritis Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 2 No 1 🙀 Yes 1 Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🖾 No 2 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: After 5 Pending Investigation 1 Natural М 1 ☐ Yes 2 ☐ No death. 2 Accident after death Director: 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a 1 Cartifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai / To the within 2 29d, Date signed (Month, Dev. Year) 29c. License number 29b. Signature and title of certified 206 February 27, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jeffrey A. Permutter, M.D. 6420 Montrose Rose Rockville, Maryland 20852 31. Date filed (Month, Day, Year) MAR 0 1 32. Pegistrar's Signature State oaks Registrar

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Funeral Director		5. Social Security Number 6. S 579-20-9844	ex □ M 2∑ F	ge (In yrs. last birth 79 Y	Months		Hours	Min.	8. Date of (Month, Aug.	Day, Ye	1924 Was	thplace (State or Foreign ountry)
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sr dea	Funeral Director	11. Marital Status	12. Was Deceden Armed Forces	?	13. Was Dec If Yes, sp	edent of Hi	spanic Orig n, Mexican	gin? (Spe n, Puerto	ecify Yes or Rican, etc.)	No-	14. Race - Am- Black, Whi	
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To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	O	20a Cortifier			death	4 - 4 11 - 1						
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Sta	ate.	Raman R. Tuli,		503 Perry gran's Signature	St. S	re. B	Mt.	каі	nier,	MD	20712	
Donich	70.5	MAR 04 2		men 1	4 1.	sa M	1					

State of Maryland / Department of Health and Mental Hygien 2 0 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** March 07, 2004 00:12 AM William Harold Dye, II /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany 17220 Beechers Avenue, S.W. **Eckhart Mines** | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. | 27-Jun-1983 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F 214-04-3985 20 Vrs Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If frem 27 is marked other than "natural" --- eny injury or other traumatic even. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 Yes 2 □ No Maryland Allegany **Eckhart Mines** 10e. Street and Number 17220 Beechers Avenue, S.W. 10f. Zip Code 10g. Citizen of What Country? 21528-U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No Specif**y**White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) self employed self employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William H. Dye, Sr. Brenda Cameron ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17220 Beechers Avenue, William H. Dye, Sr. **Eckhart Mines** Maryland 21528-S.W. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) Laurel Hill Cemetery 11-Mar-2004 Moscow Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 olin 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician disease or condition resulting in death) sudden Self inflicted can shot wound to the head /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner Due to (or as a consequence of) Hospital or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit the attending physician and hed for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 □Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Other: Certification: To 1 🗀 Inpatient 2 ER/Outpatient 3 DOA 2 No this nours after death.
neral Director: After ti 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 🗌 Pending 1 ☐ Yes 2 No subject shot himself March 7 2004 12:12AMM investigation 2 Accident 6 Could not be determined Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a To the Funeral I 1722o Beechers Ln F'burg MD residence 29a. Certifiei 1 __certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3 D 09157 March 8 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) かる Paul Snow, M.D. Doty Med Ex 31. Date filed (Month, Day, Year) 32. Registrar's Signature 124 W 3rd St Cumberland MD 21502 State Registrar MAR 0 8 2004

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Feb. **Physician** 2004 James Demczak 7:45 p M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel Millenium Health & Rehab Center Glen Burnie If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Months Days 1⊠M 2□F 88 221-09-8407 Director Nov. 13,1915 MD Usual Residence of Decedent deeth with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at MD Anne Arundel Severna Park 1 ☐ Yes 2 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ŏ 301 North Drive 21146 USA or Items 23a by Funeral 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after t ☐ Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No White Specify. Specify: 3 ₩ Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Commercial al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Carpenter Construction permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If Item 27 Is marked othe any injury or other traumatic event, once. 17 Father's Name (First Middle Last) 18 Mother's Name /First Middle Maiden Sumame: Be Paul Demczak Unavailable 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mary Basham/Niece P.O. Box 6, Goldsboro, MD 21636 Feb. 26, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, MD Glen Haven Cemetery . Signature of Funeral Service Licensee 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 2 A Part 1. Enter the disease, or complications that caused it shock, or heart failure. List only one cause on each line complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Onset and Death mmediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence off. I or Attending Physicien: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and the attending physician and hed for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) be detached 9 Unknown 9 Unknown reignificant conditions contributing to death but not resulting in the underlying cause given in Part 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 200 No Dewelto 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 1 ☐ Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, Certification: To 3 DOA 28a. Date of Injury (Month, Day Year) in by the funeral 27. Manner of De th 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel L To the Hospitel to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated and title of conflie 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hidgelyflu DITYA CHO 31. Date filed (Month, Day, Year)
MAR 0 2 2004 State Registrar

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			1. Decedent's Name (First, Middle, Las	1)						2. Date of D		Day	Year	3. Time of I	Death	
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	Examin		4a. Facility Name (If not institution, give	street and number	r)		4b. City, Town, or	Location (of Death			4c. Coun	ty of Death			
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0	H ite		20a. Method of Disposition 1 ☐ Burial 2 【 Cremation 3 ☐	Removal from State	cemet	ery, cren	sition (Name of natory or other plac	e)		/219	200	c. Location	- City or To	own, Stete		
Sattimore, bermit. Pages 1 ar Department of Hea mportant: If item	Partition (C)		* 4 □ Donation 5 □ Other (Specify		Metro	-	ltan Crem			6/04	AI	exan	dria,	Virgin	nia	
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			shock or beart failure. List only	mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, by one cause on each line.								,		Interval Betw Onset and D	veen	
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8/PU	death certificate be executed e attending physicien and of for use as the burial-transit	icai		d												
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XOD	leath certifica attending ph I for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	e of pregnancy	incy						23d. Date of delivery					
'n	death e atte	icia	in the past 12 months? 1 □ Yes 2 🕅 No				□Ectopic pregnancy □ Other (s <i>pecify)</i>						Month Day Year		ear	
S.	at the de by the a tached	hys	9 Unknown													
s, T	requires that the een signed by th nould be detache	by P	Part II. Other significant conditions of	ontributing to death	but not resulting	in the ur						tobacco use contribute to the cause of death?				
Ë	w require been sig should b											Yes 2 No 3 Probably 4 Unknown				
Vital Record	> 9 70	Completed							Was an utopsy 24b. Were autopsy findings available prior to completion of cause of							
Ĭ	The law cate has b page 2 sl	E								per	forme	1? No	death?			
ē	iician: Th certificate rector, pag	Bec	25. Was case referred to medical					26. Place	of Death	(Check only						
	nysic ais ce direc	To	examiner? 1 ☐ Yes 2 XNo	Hospital: 1 Inpai	tient 2 ER/C	outpatien	t 3 DOA Othe	er: 4□Nu	irsing Ho	me 5 Res	sidenc	e 6X10	ther (Specia	Assist Viivin		
10 C	ding Ph h. After th funeral		27. Manner of Death	28a. Date of Injury 28b. Time of 28c. Injury at Work?						28d. Describe how injury occurred						
0	Attendid death. ctor: A y the fu	atic	2 Accident investigation					Yes 2 🗌								
UNISION	al or Attence after death	Certification;	3 Suicide 6 Could not be determined	28e. Place of In building,	njury - At home, etc. (Specify)	larm, str	et, factory, office			28f. Location City or To	(Stree own, S	t and Num (tate)	nber or Run	al Route Numb	00 <i>f</i> ,	
2	spital or ours afte neral Dir		Y													
	e Hospital 24 hours e Funeral letely filled	edicai	(Check only 2 Medical Exan	ysician: To the bes niner: On the basis	of examination a	ge, death and/or inv	occurred at the ting restigation, in my of	ne, date ar pinion, dea	id place, a ith occurr	and due to the ed at the time	e caus e, date	e(s) and n and place	nanner as s , and due t	tated. o the cause(s)		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Med	29b. Signature and title of certifier	and manner s	5(d1 0 Q.		29c. License	e number			29d	Date sinn	ed (Month	Day, Year)		
	W T CO		1/0 ///	aux. X	1	7	10.7	/// <				7/	> </td <td>042</td> <td></td>	042		
10	5		ree C. Je	wrunge	MILL	/	2	-/ [()			7	-1/			
			30. Name and address of person who					J #1	00	Roths-	4.	Moss	17 and	20817		
<u> </u>	CA	to-	Lee R. Penning			rer	nwood Roa	/	.00	Bethes	ud,	, mar	утана	20017		
	Sta Registi			104 154	strar's Signature	D	gover									

Months

7. Age (In yrs. last birthday)

74

Certificate of Death

4b. City. Town, or Location of Death

If Under 1 Year If Under 24 Hrs.

Days

Annapolis

Hours

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STUANTE, SELOWIA, W.D. 900

Selonia, W.O.

32. Registrar's Signature

3. Time of Death Year 2004 2:30 4c. County of Death

Birthplace (State or Foreign Country)

White

Approximate Interval Between Onset and Death

LWHS

10d. Inside City Limits

1 ☐ Yes 2 No

Anne Arundel

USA

14. Race - American Indian. Black, White, etc.

Federal Government

10g. Citizen of What Country?

16b. Kind of Business/Industry

20c. Location - City or Town, State

23d. Date of delivery

1 Tes

29d. Date signed (Month, Day, Year)

Bestyate Rd. Annapolis, Md.

Day

2 No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

2□ No

Year

Month

Baltimore, MD

Reg. No.

Dav

2. Date of Death

8. Date of Birth (Month, Day, Year)

Month

Mar.

Jul.

Physician /Medical Examiner 1. Decedent's Name (First, Middle, Last)

5. Social Security Number

396-24-5750

Usual Residence of Decedent

Dean A. Funk, Sr.

4a. Facility Name (If not institution, give street and number)

Anne Arundel Medical Center

1⊠M 2□F

Funeral Director

State Registrar DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

MAR 0 8

For State Unpend Item#23a-1	State of Maryland / Department of Heal 27,PerME,G829,3/23/<i>Ge</i>a ificate of Dea	th and Mental Hygiene 2 (004 08	71:

MA	N		1 = State Unpend Item Registrar		State of ,27,PerM	Maryland E,G829,3	d / Depa / /23/% e	artmen <i>Bificat</i>	t of H e of L	ealth a Death	ind M		Reg.		04	0871	
	Physici	an	Decedent's Name (First, Mid			59						2. Date of Month			Year	3. Time of Death	
100	/Medi			DORG			UGITT	45 05	T	I continu o		Febr	uary	7 26, 2004 0122 A			
	Examir		4a. Facility Name (If not institute	_					inhan	Location of	Death					orge's	
			Doctors Commun 5. Social Security Number	6. Sex		. Age (In yrs. I	last birthday)			If Under 2		8. Date of	of Birth n, Day, Ye			place (State or Foreig	
	Funeral Director		577-44-5612		M 2 X F	69	Yrs.	Months	Days	Hours	Min.	FEB.	1, Day, Ye	1935	WA	SH. D.C.	
			Usual Residence of Decedent														
	how		10a. State 10b. Coun	ty		10c. City	y, Town or Lo	ocation								10d. Inside City Limits 1 XYes 2 ☐ No	
	e Ma	cto	MD. PRI	NCE (GEORGES				NHAM								
	if the	Dire	10e. Street and Number					10f. Zip					10g.	10g. Citizen of What Country?			
	72 hours after death with the Maryland "natural", or Items 23a or 28a-f show idical Examinational be rediffed at	Funeral Director	10001 GRE				6 112	Was Dass		20706	-in 2 /Cno	od. Voc	a No		.S.A	can Indian,	
	er de Items	une	11. Marital Status 1 ☐ Never Married 2 🛣 M.		2. Was Deced Armed Ford 1 ☐ Yes 2	es?	.5. 13.	If Yes, spec	offy Cuba	ispanic Orig in, Mexican	, Puerto	Rican, etc	.)		, White,		
36	rs aft	by F	3 Widowed 4 Divorce		If Yes, Give	-		1 🗌 Yes	X No	Specify:				Specify:	T.TE	ITE	
215-0036	tura stura	ed	15. Deced	ation		16a. Dece	dent's Usua	al Occup	ation			160	o. Kind of Bus				
15		piet	(Specify only high	-	College (1-	4or 5+\	(Give	kind of wo DO NOT u	rk done d se retired	during most)	of workii	ng					
212	d with	Completed	Elementary/Secondary (0-12	<u></u>	3			REGIS	TERE	D NUR	SE_			NUR	SING		
	be filed tal Hygi d other	Be	17. Father's Name (First, Middle	e, Last)						18. Mothe	r's Name	(First, M.	iddle, Mai	den Surname)		
Maryland	s i and 2 should be filed within if Health and Mental Hygiene. Item 27 is marked other then ' other traumatic event, Ita Ma	10 E	CHESTE	R	FRIED	MANN						MA	MARY McGINLEY				
an	2 sho and 1 is me	ľ	19a. Informant's Name/Relatio	nship (Ty)	oe, Print)		19b. Marii	ng Address	(Street	and Numbe	r or Rura	i Route N	umber, C	ity or Town, S	State, Zij	Code)	
	and 2 saith n 27 i		JOHN W. FUGI	TT J	R./HUSB					LT RD				AM, MD			
ore	of He of He fiten		20a. Method of Disposition 1 □ Burial 2X Crematio	n 3.⊟B	amoval from S		lace of Disponentery, cre	osition (Nar matory or c	ne of ther plac	e)	C	ate	200	c. Location - (City or T	own, State	
Ĕ	Out in the		' 4 ☐ Donation 5 ☐ Other				AMBERS	CREM	ATOF	XY	3-2-	2004		RIVE	RDAL	E, MD.	
Baltimore,	permit. Pages 1 and Department of Healt Important: If Item 2 any injury or other once.		21. Signature of Funeral Service	has	nber	A MOO	091 5	801 C	LEVE	LAND	AVE.	, RI	VERD	MATORI ALE, M	UM,P	.A. 0737	
5.0	V.		23a. Part1. Enter the disease, shock, or heart failure. L	or compli	cations that ca	used the death	h. Do not en	ter the mod	le of dyin	g, such as	cardiac o	r respirat	ory arrest			Approximate Interval Between	
1	Physician		Immediate Cause (Final disease or condition			ry embol:										Onset and Death	
7	/Medical		resulting in death)			r as a consequ											
	Examiner		Sequentially list conditions,	l t		in thron											
	D =	Examiner	1 any leading to inmediate cause. Enter Underlying Cause (Disease or injury	1	Due to (c	r as a consequ	uence of										
	cate be executed physician and the burial-transit	cam	that initiated events resulting in death) Last	٥	. Due to /c		uonoo of):								-		
68760,	icate be execu physician and s the burial-tra		resulting in obtain, past	or as a consequ	uence on;	ance off.											
87(icate b	edical			l										-	6296	
			IF FEMALE:	2	3c. If yes, outc	ome of preopa	ancy							224 Days			
Вох	atte for	Physician/M	23b. Was decedent pregnant in the past 12 gonths?	-	1 Live bir	th 2 Fetai	Ideath 3	☐Ectopic p						23d. Date Mon		ery Day Year	
o.	0 0 0	ysic	1 ☐ Yes 2 ØNo 9 ☐ Unknown		9 Unknov		eath St	_ Other (st	ociiy)				_				
<u>α</u>	requires that the de een signed by the a bould be detached to	P _h	Part II. Dther significant cond	itions cor	tributing to de	ath but not resi	ulting in the u	underlying o	ause giv	en in Part I.		23e.	Did tobac	co use contri	bute to 1	he cause of death?	
ds,	sign d be	d by											1 🗌 Yes	2 💢 No	3 🗌 Pro	oably 4 Dunknow	
Vital Records,	w require been sign	Completed										242	Was an	24h M	lore aut	ppsy findings available	
3e	has has	mp										1	autopsy performed	pi	or to co	impletion of cause of	
a	_ us c												'es 2□		XYes	2 No	
₹		Be	25. Was case referred to med examiner?	-	iospital:		50/0		Oth	er:					. (0		
of		2	1 Yes 2 No 27. Manner of Death		Hospital: The properties and the properties of t									y)			
on	ding th. After funer	ţi	1 XNatural 5 Pen	ding stigation	(Month	, Day Year)	Injury	м	Wor	k? Yes 2 🔲 l	No						
Division	or Attending ufter death. Director: After in by the fune	Certification:	3 Suicide 6 Could not be 28e, Place of Injury - At home, farm, street, factory, office 28f, Local Could not be 28e, Place of Injury - At home, farm, street, factory, office 28f, Local Could not be 28e, Place of Injury - At home, farm, street, factory, office 28f, Local Could not be 28f, Local							28f. Locat City o	ion (Stree or Town, S	et and Numbe State)	r or Rur	al Route Number,			
	ne Hospital or Attend 124 hours after death ne Funeral Director: /	Medical Ce	(Check only 20 Modic		sician: To the ner: On the ba	sis of examina											
	는 는 는 는	Med	one) 29b. Signature and title of cert	fier	and mann	er stated.		20.	c Licens	e number	·		294	Date signed	(Month	Day, Year)	
	with To	-		0 1	1	1	1 / ^										
			Jaska	()	heen	$-\omega$			O.C.	Y. E.			F	enruar	y 2	7, 2004	
			30. Name and address of pers	on who co	mpleted cause	of death (Item	n 23a) (Type	, Print)									

State Registrar 31. Date filed (Month, Day, Year)
MAR 0 3

Tasha Z Greenbers 32. Registrar's Signature

MD

111 Penn Street, Baltimore, Maryland 21201

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of

hth, Day, Year)

MAR 0 2 2004

ress of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

RITA GHOSH, M.D., 14804 PHYSICIANS LANE,

29c. License number

#221

D30132

ROCKVILLE, MD

29d. Date signed (Month, Day, Year)

MARCH 1, 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien?

		For State	State of Maryla		artment of He rtificate of L			ng UU4	08/13		
		Ragistrar 1. Decedent's Name (First, Middle, Last)				2, Date of Death Month	Day Year	3. Time of Death		
Physic /Med		Sophia Elizabeth	Foley				February	26 2004	9:20 P M		
Exam		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or			4c. County of Dea			
		Genesis Eldercare 5. Social Security Number 6. Se	Spa Creek 7. Age (In yrs	. last birthday)	Annapol:	IS If Under 24 Hrs.	8. Date of Birth	Anne Aru			
Funera Directo			□M 2 © :F	Yrs.	Months Days	Hours Min.	(Month, Day, Y Sept 21		hplace (State or Foreign buntry) land		
pu ,		Usual Residence of Decedent									
farylan show	5	Toa. State							10d. Inside City Limits 1 ☐ Yes 2 ♠No		
the A	Director	Maryland Anne Aru	ndel Ar	mapoli	S 10f. Zip Code		10g	. Citizen of What Co	ountry?		
h with	a D	21 Hull Avenue			21403		IJ	nited Sta	tes		
r deat	Funeral	11. Marital Status	12. Was Decedent Ever in I Armed Forces?	U.S. 13.	Was Decedent of His If Yes, specify Cubar	spanic Origin? (Spe n, Mexican, Puerto		14. Race - Ame Black, Whit	rican Indian,		
-UU36 hours after death with the Maryland turel', or Items 23s or 28s-f show al Exantraer must be notitized at	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1		1 ☐ Yes 2 No	Specify:		Specify: W	nite		
15-0036 72 hours at "naturel", or	ted	15. Decedent's Edi	ucation	16a. Dece	dent's Usual Occupa	ition	16	b. Kind of Business			
d 21215-0 filed within 72 hc Hygiene. hther than "natur ant, the Medical	Completed	(Specify only highest grad	College (1-4or 5+)	life.	kind of work done d DO NOT use retired)	unng most ar worki)	ng				
led wi		47 Fabrus Nama (Final Asidala Land)	2	f	rame atte	ndant 18. Mother's Name	/First Adjudgle Ada	phone con	npany		
and the filed intal Hyge ed other	Be	17. Father's Name (First, Middle, Last)									
Maryland 2 d 2 should be filed th and Mental Hygis ?? Is marked other traumatic event, I.	Jo	Frank Pikora 19a. Informant's Name/Relationship (T)	ype, Print)	19b. Maili	ng Address (Street a			Baclawski Number, City or Town, State, Zip Code)			
C = 14 F		Michael Foley/ hus	band	21 H	ull Avenue	e Annapol	is. MD 2	1403			
0 8 9 5 5		20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from State	cemetery, crei	matory or other place	9)		,			
altimor mit. Pages partment of cortent: If it		`4 □ Donation 5 □ Other (Specify) Ba				h 1, 200	4 Baltimo	re, MD		
Baltim permit. Pag Department Importent: any injury o		21. Signature of Funeral Service Licens	Romerneli		2. Name and Address	JO		_	ral Home, In MD 21401		
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between									
Physician		Immediate Cause (Final disease or condition resulting in death)	a	Is	chemic	Cangin	majorat	ly	Onset and Death		
/Medica Examine		Todaling in doaling	Due to (or as a conse	equence of):		5 6	1				
	je l	Sequentially list conditions, if any, leading to immediate cause. Linty Tudenting Cause (Disease or injury	b. Due to (or as a consequence of):								
cuted nd transit	Examiner	that initiated events	c								
38 760, icate be executed physician and s the burial-transit	a E	resulting in death) Last	Due to (or as a conse	equence of):							
68 / 60 tificate be e ig physiciar as the buria	edicai		d								
BOX 6 leath certifi attending	M/W	230. was decedent pregnant	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet		Ectopic pregnancy			23d. Date of delivery			
the deat yy the att	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown			Month Day Year						
dS, P.O. I	P.	Part II. Other significant conditions co	entributing to death but not re	sulting in the u	nderlying cause give	n in Part I.	23e. Did tobac	the cause of death?			
VI(al Hecords, P.O. Box 68/6U, siclen: The law requires that the death certificate be executed certificate has been signed by the attending physician and irector, page 2 should be detached for use as the burial-transit	d by						1 ☐ Yes	2/□No 3 □ Pr	obabły 4 Dunknown		
aw require to been size the should I	Completed						24a. Was an autopsy	24b. Were au	topsy findings available completion of cause of		
	l e						performe	d? death?	2 No		
VITAL P siclen: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:		Othe	26. Place of Death					
Of Phys	년: 1	1 Yes 2 No	1 ☐ Inpatient 2 [28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o	it 3□ DOA	Nursing Hor	ne 5 🗆 Residend 28d. Describe how	ce 6 □Other (Special injury occurred	cify)		
nding F ath. r: After e funer	atior	1 Natural 5 Pending 2 Accident investigation		Injury	Work	Work?					
DIVISION Of or Attending Physical distribution of the this in Director: After this din by the funeral din by	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, str cify)	reet, factory, office	:	28f. Location (Stree City or Town, S	et and Number or Ru State)	iral Route Number,		
DIVISION Of VITA To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical C	29a. Certifier 1 PCertifying Phy (Check only one) 2 Medical Exam	/sician: To the best of my kr iner: On the basis of examinand manner stated.	nowledge, deat nation and/or in	h occurred at the tim vestigation, in my op	e, date and place, a pinion, death occurre	and due to the caused at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)		
o the comple	Med	29b. Signature and title of certifler	and manifer stated.		29c. License			. Date signed (Monte	•		
L- > P- 0		1 / Jry / So	~www		03	7036		2/27/0	4		
		30. Name and address of person who of	ompleted cause of death (Ite	em 23a) (Type,	Print) Driv	e Chest	-, Mo	21619			
S	tate	31. Date filed (Month, Day, Year)	32. Resistrar's Sign					/			
Regis	trar	MAR 0 1 2	2004	# 1	Society						

State of Maryland / Department of Health and Mental Hygiene 2 08716 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician February 26, 2004 Jean H. Grundborg 8:20 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Bethesda Montgomery Maplewood Park Place 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Nov. 1, 1908 **Funeral** 9. Birthplace (Stete or Foreign 1 □ M 2 🗑 F Days Hours New York 219-50-9125 95 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location ns 23a or 28a-1 show 10d. Inside City Limits 1 ☐ Yes 2 📉 No Directo MD Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9600 Accord Dr. 20854 U.S.A. by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after di Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or flarr any injury or other traumatic event, Ite Medical Examination. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Stanley Peplos Marta Bogdanovich ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth Grundborg Son 1208 26th Street South Arlington, VA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington Nat'l Cem. 3/11/2004 Arlington, Virginia * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Joseph Gawler's Sons, Inc. 21. Signature of Funeral Service Licenses 5130 Wisconsin Ave., NW, Washington, DC 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) END STAGE DEMENTIA Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, a y, leading of infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the death certificate be executed burial-transit and Due to (or as a consequence of): attending physician by Physician/Medical as the IF FEMALE: **BSN** 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ŏ 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐ Pregnant at time of death Month Day Year 5 Other (specify) detached the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? pe 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performat? Yes 2121-No certificate 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 2 ER/Outpatient 3□ DOA this To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred or Attending 5 Pending investigation Injury 1 💢 Naturai death. 2 Accident 1 Yes 2 No Director 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Momicide To the Hospitel c within 24 hours a To the Funerel 6 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) D35791 February 27, 2004 70 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

Division of Vital Records, P.O. Box 68760

32. Registrar's Signature

9801 Georgia Avenue #227 Silver Spring, MD 20902

Merlyn K. Vemury, M.D.

MAR 0 5

31. Date filed (Month, Day, Year)

State of Manyland / Department of Health and Mental Hygiona

		State of Ma	C	ertificate of	Death		leg. No.	004	08717
		1. Decedent's Name (First, Middle, Last)		7.5.44		2. Date of Dea Month			3. Time of Death
	Physician /Medical	Frances Patricia Gowling				Februar	y 26, 2	004	7:56 AM
	Examiner	4a Fecility Name (If not institution, give street end number)			4b. City, Town, or Lo	cation of Death	4c. County	of Death	
		Shady Grove Adventist Hospi			Rockvill		Montg	omery	
I	Funeral Director	089-03-7709 1□M 2XF	(In yrs. lest birthde	Months Days	Hours Min.	8. Date of Birth (Month, Day Dec. 30	Year) , 1910	9. Birthplac Country New Yo	ce (State or Foreign r) ork
	p	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or	Location				10d	I. Inside City Limits
	ath with the Merylence 23a or 28a-1 show must be notified at 9rai Director	Maryland Montgomery	Potomac						1 ☐ Yes 2 🕅 No
	tha note note rect	10e. Street and Number	TOCOMAC	10f. Zip Code		1	0g. Citizen of V	Vhat Country	1?
	offer death with the Mei r frems 23a or 28a-f si direct must be notified funeral Director	13221 Beall Creek Court		20854			United		
	ms 2	11. Marital Status 12. Was Decedent E	ver in U,S. 1	3. Was Decedent of H	lispanic Origin? (Spe		14. Rac	e - American	Indian,
0200-91212	or F.	Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ☑ No. 1 □ Yes 2 ☑ No. 1 □ Yes 2 ☑ Year or Dates:		1 ☐ Yes 2 No	Specify:	Hican, etc.)		k, White, etc Whit	
ج م	72 ho	15. Decedent's Education (Specify only highest grede completed)	16a. De	cedent's Usual Occup	ation	na	16b. Kind of Bu	siness/Indus	itry
7	ithin an	Elementary/Secondary (0-12) College (1-4or 5+	·)	ve kind of work done of DO NOT use retired	daning most of worki	ng .			
	ed w ygian f. fr	5+	Tead	cher			Educat		
Maryland	wild be filed within 72 ho. Mantel Hygiana. rked other than "nature sitic event, the Medical is TO Be Completed	17. Father's Name (First, Middle, Last)			18. Mother's Name		Maiden Surnam	Θ)	
ž	J Mar marke	Frances O'Connor	401.44	··· • • • • • • • • • • • • • • • • • •	Rena Jon				
Z	d 2 st th end 7 is n traur	19a. Informant's Name/Relationship (Type, Print)		iling Address (Street					
a)	Heeli Heeli em 2	Tom Gowling/Son 20a. Method of Disposition	20b. Place of Dis	21 Beall C	1	Date	nac, Mat 20c. Location		
saitimore,	agas in H in the	1 ☐ Burial 2 X Cremation 3 ☐ Removal from State	Montgome	ematory or other place ry ium, Inc.		eb. 29,			
	ortma ortani injury	4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee	Cremato	Tium, Inc.		2004 1	Bethesda umphrev	Fune	yland
Ď	Demi Depe Impo any ir	5-28A-		22. Name and Addres Bethesda-Cl Bethesda, 1			7557 W:	iscons	in Avenue
		23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line	he death. Do not e	nter the mode of dyin	g, such as cardiac o	r respiratory arre	est,	Aţ	oproximate terval Between
	Physician	- 10						Ö	nset and Death
A. C.	/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) a Pericard	ial Tampo	nade				20	Minutes
		resulting in death)	ue to (or as a cons					1	
	ficate be axecuted physician and is the bunal-transit	b						1	
	rificate be axecuted no physician and as the bunial-transit	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events	ue to (or as a cons	equence of):				I	
00/00	s be a siciar s buri	Cause (Disease or injury that initiated events							
9	ficate p physics the street	resulting in death) Last	ue to (or as a cons	equence of):					
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•	daeth a etta id for ilcia	Part II. Other significant conditions contributing to death but	not resulting in the	underlying cause give	en in Part I	23h. Did to	hacco use con	tribute to th	e cause of death?
	t tha by th techs								ly 4 ☐ Unknown
ń	as the igned ba de	Pacemaker							
2	an s	Cardiac Disease				24a. Was ar		availal	autopsy findings ble prior to
נ	Tha law raquir sata has baan s paga 2 should Completed	Oaldiac Disease				·		compl of dea	etion of cause th?
_	Tha eta h					1.J¥a	s 2X No	1 □ Y	es 2□ No
9	artific actor.	25. Was case referred to medical examiner?			26. Place of Death	(Check only one	ə)		
5	this cal dire		2 X ER/Outpati		4 LI Nursing Horr				
	Ing P	27. Manner of Death 1 Matural 5 Pending (Month, Dey)	rear) 28b. Time Injury	Work		8d. Describe ho	w injury occurre	bd	
	tend deeth deeth tor: , tha icat	2 Accident investigation 3 Suicide 6 Could not be	. At home form	M 1 1	Yes 2□No	8f. Location (Str	and Alumba	a or Dural D	auto Mumbar
3	tal or Attending P rs after deeth. el Director: Attart led in by tha funars Certification:	4 Homicide determined 286. Place of Injury building, etc.	(Specify)	ileer, ractory, onice	-	City or Town		i vi nurai ni	ute reamber,
•	ours ours filled	29a. Certifier	ny knowledge, dea	th occurred at the tim	e, date and place, a	nd due to the ca	use(s) and man	ner as state	d
	To the Hospital or Attending Physician: Tha law ra within 24 hours after deeth. To the Funeral Director: After this cartificate has bar completely filled in by the funeral director, page 2 show the funeral director.	(Check only one) 2 Medical Examiner: On the basis of examiner state and manner state	xamination and/or i	nvestigation, in my op	inion, death occurre	d at the time, da	te and place, a	nd due to the	cause(s)
	within To the comp	29b. Signature and title of certifier		29c. License	number	29	d. Date signed	(Month, Day	Year)
	/	· Clarmshyde	M.D.	D59929)	F	ebruary	26.	2004
	27	30. Name and address of person who completed cause of dea			, '				
	210	Aaron Snyder, M.D. 9901 Med	ical Cent	er Drive,	Rockville	, MD 20	850		
	State	31. Date filed (Month, Day, Year) 32. Registrar's	s Signature	1	,				
	Registrar	MAR 0 1 2004	10	sparker	/				

DHMH 16 Rsv 6/95

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** February 29 4:42 2004 Giese Raymond Thomas /Medical 4c. County of Deeth 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery 6. Sex 1 XM 2 ☐ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** Days Hours 80 Director 513-18-7753 Feb. 11, 1924 Kansas Usual Residence of Decedent with the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygeine. Industrial the Charles of Health and Mental Hygeine. Industrial: If item 27 a marked other then "patural", or Itama 23a or 28a-1 ehow any injury or other traumatic event. It is Medical Examine must be intillised as 1 X Yes 2 □ No Gaithersburg Maryland Montgomery Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20879 1334 Carlsbad Drive United States Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 MYes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1949-1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: White þ 3 X Widowed 4 □ Divorced 1958 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Furniture Store Manager 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mary Hunner Albert Giese ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1334 Carlsbad Drive Gaithersburg, MD 20879 Barbara Chomycia / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) March 5, Resurrection Cemetery 2004 Clinton, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DeVol Funeral Home 10 E. Deer Park Dr. Gaithersburg, MD 20877 23a. Part 1. Enter the discase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or high failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician -organ disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Severe 1sche mia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner occlusive disease The law requires that the death certificate be executed the attending physician and thed for use as the buriat-transit Phera that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Yes 2 No detached 9 🗆 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 4 Onknown ctive 3 Probably 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate aortic 2 1 No oració 1 Yes 2 No 1 Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) in by the funeral 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier march 3, 2004 D24773 +1 10850 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9715 medical Center Drive, Rockville, Maryland Kobert L. Fox, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 05 racks Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death February 25, 2004 **Physician** Audrey Ellen Garland 9:18 P /Medical 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) Days Hours 1□M 2√2F 579-03-7458 86 Director Sept. 12, 1917 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location rthan "natural", or Itams 23a or 28a-f show the Medical Examiner must be redified at 10d. Inside City Limits Director 1 Ty Yes 2 □ No Maryland Prince George's College Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20740 4711 Berwyn House Rd. #713 USA Pages 1 and 2 should be filled within 72 hours after death neat of Health and Mental Hygiene.
and it fleat 15 a marked other than "natural", or flems 23 and it if then 15 a marked other than "natural", or liber fraumatic avant, the Mancal Excellent fraumatic avant, the Mancal fraumatic fraumatic avant, the Mancal fraumatic fraumat Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, GiveX Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🛣 No Specify à Specify: 3XXWidowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Naval Surface Elementary/Secondary (0-12) College (1-4or 5+) Weapons Center 12th Cashier 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William Asa Beall Amy Lavinia Mulligan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Debra Pecora- Daughter 1769 Millwood Way Suffolk, VA 23434 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If its any injury or of once. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cemetery 03/01/2004 Brentwood, MD 4 ☐Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home 11800 New Hamsphire Ave. Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Weeks Neumonia resulting in death) /Medical Due to (or as a consequence of): **Examiner** lostridum withicite colitin Week Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 menths?
1 Yes 2 No 23d. Date of delivery 2 Fetal death 3 □Ectopic pregnancy ó Month Year Day 4 Pregnant at time of death 5 Other (specify) P.O. I the be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy eged . 1 Yes 2 12 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 ☐ ER/Outpatient 3□ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident the within 24 hours after death To the Funeral Director: 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number D-20062 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Street, SILVER SPRING, MARYLAN 20910 TONY P.KANNARILAT. MD 8201 31. Date filed (Month, Day, Year) 32. Registrar's Signature ands! 01 2004 Registrar

		•	1 - For State Registrar	State of I	Maryland	/ Depa	rtment	of H	ealth a Death	and M		Reg. No.	004	0872	0
	Dhusisi		1. Decedent's Name (First, Middle, La	ist)							2. Date of Dea Month	Day	Year	3. Time of Death	
	Physici: /Medic		James D. Georg								Februar		2004	8:25 A	M
	Examin	er	4a. Facility Name (If not institution, given	e street and numb	er)		•		Location o				unty of Death		
			Holy Cross Hosp		Age (In yrs. las	t hirthday)	S:		r Spr		8. Date of Birt		ntgome		ion
	Funeral Director			ΜΩΜ 2□F /.	79	Yrs.		Days	Hours	Min.	June 19	v, Year)	4 Nev	pplace (State or Fore intry) 7 York	gn
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	within 72 hours after death with the Maryland ene. than "naturel", or Items 23e or 28e-f show he Medical Examinar must be notified at	5	10a. State 10b. County		10c. City, 1									1 XYes 2 ☐ I	
	the M	Director	Maryland Montgo 10e. Street and Number	mery		Silve	er Spi					10a. Citizer	of What Co	untry?	
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	ns 23	era	11. Marital Status	12. Was Decede		13. \	Vas Deced	ent of Hi	spanic Ori	gin? (Spe	ecify Yes or No-		Race - Ame		
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<u>7</u>	"natu	lete	15. Decedent's E (Specify only highest gr	ducation ade completed)		(Give	lent's Usua kind of wor DO NOT us	k done d	uring mos	t of worki	ing	16b. Kind	of Business/I	ndustry	
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<u> </u>	Hyg other ent,	Be C	17. Father's Name (First, Middle, Las							er's Name	(First, Middle,	Maiden Su	mame)		
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or Items 23a or 28e-f show any Injury or other treumatic event, the Medical Examinar must be notified at ADE.	To E	Will	iam Georg	geson						Amali	a Gri	pioti		
lan	and I		19a. Informant's Name/Relationship	(Type, Print)	1		5000 1				il Route Numbe				
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Baltimore,	artmer artment ortent Injury		' 4 ☐ Donation, 5 ☐ Other (Special Signature of Funeral Service Lice		THE V									al Home	-
Ba	permi Depa Impo any li		> Markelluli											MD 21037	
	This stee		23a. Part1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Finat	one cause on eac	h line.		er the mode	of dying	g, such as	cardiac o	or respiratory ar	rest,		Approximate Interval Between Onset and Death	
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687	ficate physis the			d											
Box (death certifics e attending pt ed for use as t	N/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	me of pregnand		Ectopic pre					23d	. Date of deli	,	
O. B.	w requires that the death certifica been signed by the attending ph should be detached for use as tt	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		t at time of dea		Other (spe						Month	Day Year	
Δ.	The law requires that the tite has been signed by thoage 2 should be detache	/ Ph	Part II. Other significant conditions	contributing to deal	th but not resulti	ing in the u	nderlying ca	ause give	en in Part I		23e. Did to	bacco use	contribute to	the cause of death?	
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isio	Attending ir death. ector: After by the fune	Icat	2 Accident investigate 3 Suicide 6 Could not	be ass Blace of	I Injury - At hom	e farm str			Yes 2□		28f. Location (5	Street and N	lumber of Ru	ral Route Number,	
Division of Vital	or Attendater death Director:	Certification;	4 Homicide determine	building	, etc. (Specify)	0, 14111, 511	out, rectory	, 011100			City or Tox				
	To the Hospitel or Attending Phys within 24 hours after death. To the Funerel Director: After this completely filled in by the funeral di	edical C	29a. Certifier 1 X Certifying F (Check only one) 2 Medical Exa	hysician: To the base	is of examinatio	edge, deatl n and/or in	occurred a	at the tim	ne, date an pinion, dea	nd place, ath occurr	and due to the e	cause(s) an date and pla	d manner as ace, and due	stated. to the cause(s)	
	ro the vithin o the comple	Me	29b. Signature and title of certifier				29c	License	number			29d. Date s	igned (Month	Day, Year)	
	F > F 0		1 Lellin	Ja 1	m_		1	D323	22				2-26	5-04	
			30 Name and address of person who	completed cause	of death (Item 2	23a) (Type,	Print)								_
			Suresh K. Gupta		9801 Geo	orgia	Ave.	#2:	20, s	ilve	r Spring	, MD	20902		
	Sta Regist	ate	31. Date filed (Month, Day, Year) MAR () 1	2004 32. R	istrar's Signatui	re	back		•						
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State of Maryland / Department of Health and Mental Hygiene 2004 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day Year 25 aM march 2004 /Medical Brian W. Garland 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Doctors Community Hospital Lanham Prince 9. Birthplace (State or Foreign Country) If Under 24 Hrs. **Funeral** 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1√2 M 2□ F Hours Director 213-72-4785 8-16-59 WV Usual Residence of Decedent r 28e-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Directo Prince Georges University Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō item 27 is marked other than "natural", or items 23a or other traumatic event, it a Modical Execution 1, usi be 6805 Adelphi Completed by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give △ Year or Dates: Maryland 21215-0036 1 ☐ Yes 21 No Specify: Specify: Black 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "na any injury or other traumatic even." Elementary/Secondary (0-12) College (1-4or 5+) 12 Wechts - Retail Executive 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James W. Garland Leola G. Perry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 53 W. Hampshire St. Piedmont, WV. 26760 Francine Thornton Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 3-6-04 Garden Potomac Memorial Keyser, WV 21. Signature of Fineral Service Licensee 22. Name and Address of Facility Fredlock Funeral Home W m 31 Jones St. Piedmont, WV. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PNEYMONIA **Physician** /Medical Examiner IMMUNODEFICIENCY SYNDROM or any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner certificate be executed burial-transit MOHOMA that initiated events resulting in death) Last and D e to (or as a consequence of): Box 68760, the attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) P.O. 1 ☐ Yes 2 ☐ No 9 Unknown 9 🗆 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ Completed 1 ☐ Yes 2 ☐ NO 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Wasan certificate has page 1 ☐ Yes 2 110 funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 4 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3□ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) After t 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred or Attending 1 Natural 5 Pending after death.

Director: Aft 2 Accident investigation М 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be Płace of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours after To the Funerel Dire 4 ☐ Homicide To the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical completely (Check only one) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MESTIGET, My 40170 GLOVEL 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 2004 4 Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 08722 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** HURLEY Year BERLIN MARCH 2004 /Medical 4b. City, Town, or Location of Death 4e. Fecility Name (If not institution, give street and number) 4c. County of Death Examiner Shady grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Adonths | Davis | Hours | Min. | (Month, Dey, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 10 M 2□ F 404-10-7055 93 Director May 14,1910 Kentucky Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or Iteme 23s or 28s-f show the Mudical Exprimer count be notified at 1 ☐ Yes 2 No Md. Montgomery Boyds Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14200 Clopper Rd. 20841 United States 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Peges 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than 'eny injury or other fraumatic event, The Managare. Elementary/Secondary (0-12) Montgomery County College (1-4or 5+) Custodian Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John Hurley Polly Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15301 Comus Rd. Boyds, Md. 20841 Cecil Hurley (Son) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Mar. 6, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) Resthaven Cemetery Frederick, Md. 2004 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service License 10 East Deer Park Dr. Gaithersburg, Md. 20877 23a. Part1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) RESPIRATORY FAMIURE Physician HYPOXIC 2 DAYS /Medical **Examiner** NEUMONIA SPIRATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infliated events resulting in death) Last Due to (or as a consequence of) Examiner -transit To the Hospitef or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) physicien a the burial-Box 68760 Physician/Medical IF FEMALE esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ğ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 Other (specify) ned by the a P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 3 Probably 1 Tyes 2 No 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Wasan 2 No 1 ☐ Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 10 1 ☐ Yes 2 🖫 No 1 Impatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 1 ENatural 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0055068 MARCH 03, 2004 30. Name and address of person who Impleted cause of death (Item 23a) (Type, Print) , SHADY GROVE ADVENTIST HOSPITAL , ROCKVILLE , MD. SHUBIR SOFAT 31. Date filed (Month, Day, Year) 32. Registrar's Signature MAR 0 5 2004 Registrar

			1 - For State Registrar	State	of Maryland	/ Depa	artment of H	lealth a Death	nd Ment	al Hygie Reg.	ne 200	4 08723
		- 1	1. Decedent's Name (First, Middle	, Last)						ate of Death		3. Time of Death
	Physici /Media		Marion V	eronica F	lunter					onth bruary	Day Year 29, 2004	2:30 a M
	Examir		4a. Facility Name (If not institution,				4b. City, Town, or	Location of		Jaary	4c. County of Dea	
			Hillhaven Nurs	ing Cent	er		Adelphi				Prince (George's
	Funeral			6. Sex	7. Age (In yrs. las		If Under 1 Year Months Days	If Under 2	4 Hrs. 8. Da	ate of Birth fonth, Day, Ye	9. Bir	thplace (State or Foreign ountry)
Н	Director		157-10-8771	1 ☐ M 2 🛣 F		91 ^{Yrs.}	Months Days	Hours		nuary 2		Italv
	pu ,		Usual Residence of Decedent		1.0 01							, ,
	aryla shov	_	10a. State 10b. County		10c. City,	Town or Lo	cation					10d. Inside City Limits
	Ba-f	cto	Maryland Montg	omery	Si	lver	Spring					1 ☐ Yes 2 ☑ No
	or 2	Directo	10e. Street and Number				10f. Zip Code			10g.	Citizen of What Co	ountry?
	ath w		9515 St. Andrew				2090	1			USA	
	teme	Funeral	11. Marital Status	Armed F			Vas Decedent of Hi Yes, specify Cuba	ispanic Origi n, Mexican,	in? (Specify Y Puerto Rican,	es or No- etc.)	14. Race - Ame Black, Whit	erican Indian, te, etc.
36	s afte	by Fi	1 Never Married 2 Marri	If Yes, G		1	☐ Yes 2 No	Specify:			Specify: Whi	1+0
21215-0036	hour		3 XWidowed 4 Divorced	Year or I		15a Danas	and Harri					
5	n 72	Completed	15. Decedent' (Specify only highes	grade completed)	(Give	ent's Usual Occupa kind of work done of OO NOT use retired,	ation furing most (of working	166	. Kind of Business	Industry
2	withi ene. then	m	Elementary/Secondary (0-12)	College	(1-4or 5+)			,			0 11	
	be filed within 72 hours after death with the Maryland tal hygiene. do other than "natural", or iteme 23e or 28e-f show adont, the Mudical Examiner must be muffled at	ပိ	17. Father's Name (First, Middle, L	_ast)		поше	maker	18. Mother	's Name (First	Middle Maid	Own Honden Sumame)	1e
a	od be	Be c	Louis Giu								•	
Maryland	houted Me	2	19a. Informant's Name/Relationsh			19h Mailin	g Address (Street a	Ma Ma Number	ria Cl	ara Loc	cigno	Zio Codo)
<u>8</u>	d 2 s th an 17 is											
	1 an Heall em 2		George E. Hunte 20a. Method of Disposition	r, Jr./ S		951 ee of Dispos	5 St. And	rew s	Way,	Silver	Spring. Location - City or	MD 20901
چ	To His		1 ☑ Burial 2 ☐ Cremation		State cerr	netery, cren	natory or other place	i lilia	arch 4,			
ΠŢ	rt Pi		`4 □ Donation 5 □ Other (Sp		HOTZ		Cemeter		2004	Ne	rsey City w Jersey	
Baltimore,	permit. Pages 1 and 2 should be fill Department of Health and Mental Hill Importent: If Item 27 is marked oth any injury or other treumstic sven once.		21. Signature of Funeral Service L	icensee	-	Fr	Name and Addres	Çolli	lns Fun	eral H	ome Inc.	ing. MD 20901
			220 Parts Fotos Midiodes as	July 1	saves d the death	Do not onto	Univer:	sity E	31vd. W	. , Si	lver Spr	ing. MD 20901
Ь			23a. Part1. Enter the disease, or a shock, or heart failure. List of	-				g, such as ca	ardiac or respi	iratory arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Cardí	ac Decor	mpensa	ation					Grisor and Death
3	/Medical Examiner		resulting in death)		(or as a consequer							
-3	ZAGIIIIICI	_	Sequentially list conditions,		stive Car		opathy					
	pe jis	lue	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury		or as a consequer							
	and -tran	Examin	that initiated events resulting in death) Last		lar Heart		ease					
8760,	cate be executed physician and the burial-transit				atic Hear		.0000					
	ate the	dlcal		d. Itircum	idere near	L DIE	ease					
×		(t) +	IF FEMALE:	OZa If year or	stacms of examples							
ROX	death certifi e attending ed for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 Live	itcome of pregnance birth 2 Fetal de	eath 3 🗌	Ectopic pregnancy				23d. Date of del Month	ivery Day Year
<u> </u>	0 0	/sic	1 Yes 2 No	4∐ Preg 9□ Unkr	nant at time of deat nown	th 5∐	Other (specify)					
J.	that the de led by the a detached f	Ph)	Part II. Other significant condition	ne contribution to (looth but not consti	ee ie the	dashina as as	a ia Dani I	01	a Did tahaaa		the cause of death?
Š,	SB - 50 - 60	by	Senile Dementia				denying cause give	mmrant.	2			
0	w require been si should t	sted		OI MIZH	ermers ry	/pe			-	1 1 195	2 <u>X</u> 1140 3[]F1	obably 4 Unknown
Hecords,	> 44 (0	ompleted							24	a. Was an autopsy	prior to d	topsy findings available completion of cause of
I	(0	Co							1[performéd′ ∐Yes 2⊠	? death? No 1 ☐ Yes	2 🗆 No
Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?					26. Place o	of Death (Chec	ck only one)		
0	Physic this c	2	1 ☐ Yes 2 🔀 No	Hospital:	Inpatient 2 EP	VOutpatient	3□ DOA Othe	r: 4⊠ Nurs	ing Home 5	Residence	6 □Other (Spec	cify)
	ng ftei ine	on:	27. Manner of Death 1 Natural 5 □ Pending	28a. Date (Mor	of Injury 28 ofh, Day Year)	Bb. Time of Injury	28c. Injury Work	at ?	28d. De	escribe how in	jury occurred	
200	Attending P ir death. ector: After by the funera	catl	2 Accident investiga	ation			M 1 🗆 Y	′es 2□No	0			
DIVISION	or Ati	Certification;	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ned 200. Place	e of Injury - At home ling, etc. <i>(Specify)</i>	e, farm, stre	et, factory, office		28f. Lo Cit	cation (Street by or Town, St	and Number or Ru ate)	ral Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Ce										
	Hosp 4 hot Fune ely fi	edicai	(Chack only) 2 Medicel E	Physicien: To the kaminer: On the h	e best of my knowle basis of examination	edge, death	occurred at the time	e, date and pinion, death	place, and due	e to the cause	(s) and manner as	stated.
	the I the I the I	Med	0,0)	and mar	nner stated.							
	To Con	~	29b. Signature and title of certifier	/////	12	_	29c. License	number		29d. [Date signed (Month	n, Day, Year)
•	5		~ Juyy	The			H4583	19			March 2,	2004
			30. Name and address of person w	no completed cau	se of death (Item 23	3a) (Type, F	rint)					
				M.D.		54	ll Cedar	Ave.	#202A,	Bethes	sda, MD	20814
	Sta Registr	_	31. Date filed (Month, Day, Year) MAR 0 3	2004	Registrar's Signatur	4	Sparks	1				
100	ricgisti	er	mrui v o	LUUT /		100	Land March					

State of Maryland / Department of Health and Mental Hygiene 2001 08724 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician WILFRED HOPPIE FEBRUARY 29, 2004 4:11P. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 GM 2 □ F Months 218-59-8946 Director 84 Nov. 5, 1919 Guyana Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show other traumatic avant, the Modical Extrainer canst be notified at 1 Yes 2 No Directo Maryland Prince George's Beltsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 3822 Evans Trail Court Items 23a 20705 Guyana Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or Items 23 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No if Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: Black Specify: 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Education Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George Hoppie Virginia Pistano 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3822 Evans Trail Court Beltsville, Maryland 20705 e of Disposition (Name of Date 20c. Location - City or Town, State Leila Mitchell -Daughter Ant of He.
Antant: If item 2)
Antinjury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Department of Important: If any injury or Metropolitan Crematory 3/6/2004 Alexandria, Virginia * 4 ☐ Donation 5 ☐ Other (Specify) Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705 21. Signature of Funeral Service License enold 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) **Physician** Chronic Respiratory Failure /Medical Due to (or as a consequence of): Examiner Severe Chronic Obstructive Lung Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. attending physicien Physiclan/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be Chronic Renal Failure - dialysis dependent; 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Hypertension 24a. Wasan las autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 XNo director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospitaf: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To this 27. Manner of Death 28a. Date of fnjury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: the 6 Could not be determined 3 Suicide 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide Hospital within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) au D53199 March 1, 2004 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) Natasha Lamming-Lee, M.D. 7601 Carroll Avenue, #360 Takoma Park, Maryland 20912 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 03 Registrar

			1 - For State Registrar	State of I	Marylar	nd / Depa	artmen rtificat	t of H e of L	ealth a Death	and M		giene 2	004	08725
	Physici	ian	Decedent's Name (First, Middle, Last,								2. Date of Dea Month	ath Day	Year	3. Time of Death
2	/Medio Examir		Fortunata 4a. Facility Name (If not institution, give			-	4b. City,	Town, or	Location o	of Death	March		ty of Deeth	5:36 P M
	LAdilli	ici	Washington Adven	tist Hos	pital		Та	koma	Park				ntgom	erv
	Funeral		Social Security Number 6. Security Number		Age (In yrs.	last birthday)	If Under Months	1 Year Days	If Under:	24 Hrs. Min.	8. Date of Birt (Month, De)			olece (State or Foreign
l,	Director		215-41-0459 Usual Residence of Decedent		81	Yrs.					June 1,	1922	Boli	via
	yland		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation						1	10d. Inside City Limits
	e Mar	ctor	Maryland Prince	George!	S	Ade1ph	1							1 ☐ Yes 2 ☑ No
	with th	Directo	10e. Street and Number				10f. Zip	Code				10g. Citizen o	f What Cour	ntry?
	ours after death with the Marylan rat', or Itsms 23a or 28a-1 show Examinar must be mulffed at	Funeral	8215 18th Avenue	12. Was Decede	nt Ever in U	I.S. 13 '		20783		nin? (Snec	rify Yes or No-	U.S	SA ace - Americ	can Indian
٥	after d or Itan rainar	Fun	1 Never Married 2 Married	Armed Force 1 ☐ Yes 2	s?	1					cify Yes or No- lican, etc.)	i	lack, White,	etc.
1215-0036	within 72 hours after death with the Maryland ene. then "natural", or Items 23s or 28s-1 show the Medical Examinar must be invitted at	d by	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Date	s:		1 X Yes	2∐ No	Specify:	Boli	vian	Spec	whi. Whi	te
7	s within 72 hours piene. r then *naturel', the Medical Ex-	Completed	15. Decedent's Edu (Specify only highest grad			16a. Deced	dent's Usua kind of wo DO NOT us	rk done d	urina most	of workin	g	16b. Kind of	Business/In	dustry
	s within	omp	Elementary/Secondary (0-12)	College (1-4d	or 5+)		naker	JC 10(110U)				Own	Home	
Maryland 2	를 수를 된	BeC	17. Father's Name (First, Middle, Last)						18. Mothe	r's Name	(First, Middle,	Maiden Suma	ame)	
<u>S</u>	should be find Mental I	To	Anacleto Herrera								el Guar			
Mai	d 2 sh th and 7 is rr traum		19a. Informant's Name/Relationship (Ty								Route Numbe			Code)
<u>ნ</u>	of Health and Should to Health and Ment (item 27 is marked rother traumatics).		Maria A. Claros/ 20a. Method of Disposition	Daughte	20b. F	Place of Dispo	sition (Nan	ne of		Da	phi, M	D 2078 20c. Location		own, State
<u> </u>	Pages ent of nt: #1		1 ☐ Burial 2 【XCremation 3 ☐ F 1 ☐ Donation 5 ☐ Other (Specify)	emoval from Sta	(8	cemetery, crer tropol:	-		1 1	1arch			,	Virginia
Baltimore,	permit. Pages 1 Department of H Important: If its any injury or otl		21. Signature of Funeral Service License	9 /		22	Nama an	d Address	s of Facility	,	04			
n	8988		Fucheral L L 23a. Pert 1. Enter the disease, or compliance of heart failure. List only or	aleo		50	ancis O Uni	J. vers	ity E	ins F Blvd.	uneral W., S:	Home I	nc. pring	. MD 20901
	Physician /Medical Examiner	r	shock, or heart failure. List only or immediate Cause (Final disaase or condition resulting in death) Sequentially list conditions, if any, leading to immediate	Due to (or	as a conseq	quence of):	ra(He	2mi	DY (hag-	esi,		Interval Between Onsat and Death
,09/80	cate be executed physician and the burial-transit	dical Examine	ri any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last		as a conseq									
C. Box 6	it the death certific by the attending pi tached for use as t	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	3c. If yes, outcor 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknowr	2 Feta at time of d	ıl death 3 □	Ectopic pro						ate of delive	ory Day Year
ras, r	w requires that the been signed by the should be detache	þ	Part II. Other significant conditions con	tributing to death	but not res	ulting in the ur	nderlying ca	ause givei	n in Part I.					ne cause of death?
II Record	The law ate has b page 2 sl	Completed					<u></u>				24a. Was a autops perform	sy	prior to cor death?	psy findings available inpletion of cause of 2 No
VII	Physician: Th this certificate rat director, pag	Be	25. Was case referred to medical examiner?	ospital:				Other	-	of Death	Check only or	10)		
on or	ding Phys h. After this funerat di	tlon: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 Minpa 28a. Date of Ir		28b. Time of Injury		8c. Injury Work	4 🗆 Nur	28	e 5 🗆 Reside 8d. Describe he			<i>(</i>)
DIVISION	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of building,	Injury - At he etc. (Specif	ome, farm, stre y)	et, factory		-291WI		of. Location (Si City or Town	treet and Num n, State)	ber or Rura	l Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Diract completely filled in by	edical (29a. Certifier 1⊠ Certifying Phys (Check only 2 Medical Examir one)	sician: To the be ner: On the basis and manner	of examina	wledge, death	occurred a restigation,	at the time in my opi	e, date and inion, deat	place, an	d due to the c	ause(s) and m ate and place	nanner as st , and due to	ated. the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	w/			29c	License	number		2	9d. Date sign	ed (Manth, I	Day, Year)
	1		· Mys	X				D507	791			2/	5/00	1
			30. Name and address of person who co					le D		C 4 1			00000	
	Sta	ite	31. Date filed (Month, Day, Year)	32. Regi	strar's Signa		1			SITVE	r Spri	ng, MD	20902	
	Registr		MAR 0 5 200	14 AR	carpar	15	100	aks	/					

State of Maryland / Department of Health and Mental Hygiene 0 0 1 08726 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 2004 Howard Carroll Heron March /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) **Examiner** Silver Spring Montgomery Holy Cross Hospital Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 ☑ M 2 ☐ F Director 061-16-3327 83 3, 1921 Pennsylvania Usual Residence of Decedent death with the Maryland al Hygiene i other than "natural", or items 23a or 28a-f show ivant, it.a Medical Exercises must be recitified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Director Silver Spring Maryland | Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 2211 Badian Drive 20904 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene Important: if item 27 is marked other than "natural; or ital any injury or other traumatic avent, the Wedical Erent and DRE. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1943 -1981 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White ģ 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Commander U.S. Navy 4 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 2 George Leonidas Heron Marie Catherine Howard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Kathleen M. Parker/ Daughter 1552 Eversham Place, Crofton, MD 21114 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State March 6, 2004 1

Burial 2 □ Cremation 3 □ Removal from State St. Mark's Episcopal Cemetery * 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, Maryland 21. Signature of Funeral Service Licensee Kein Stiles Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Page. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final **Physician** a Acute Myocardial Infarction disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner b Atherosclerotic Cardiovascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed Due to (or as a consequence of): attending physician a for use as the burial Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ has been signed 2 should b 1 Yes 2 No 3 Probably 4 ♥Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page certificate 1 Yes 2 √ No To the Hospital or Attending Physician: ector, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ▼ No 2 2 ER/Outpatient 3₩ DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Injury 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident To the Funeral Director: completely filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide Medical (Check only within 24 one) 29d. Date signed (Month, Day, Year) 29b. Signature and fittle of certifie D24348 10 March 3, 2004 completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who Steven Grufferman M.D. 1500 Forest Glen Road, Silver Spring, MD 20910 31. Date filed (Month, Day, Year) 32. Registrar's Signature State ener MAR 05 oaks Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 08727 State
Registrar/AMEND#26pertMD3/3/04, BMW, McCo Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Feb. 27, 2004 2004 **Physician** Hartley 5:25A. Kenneth Martin /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince George's College Park 5020 Paducah Road If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Oct. 29, 1927 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□M 2□F Illinois 76 Yrs. 322-20-1265 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23e or 28a-f show the Medical Examiner must be notified at College Park Prince George's Maryland 1 Yes 2 □ No Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20740 United States 5020 Paducah Road 12. Was Decedent Ever in U.S. Armed Forces? 1 □X/es 2 □ No If Yes, Give Year or Dates:1965—1968 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: Completed by White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Federal Government Lab Technician 12 Pages 1 and 2 should be filed w thent of Health and Mental Hygie trant: If item 27 is marked other t jury or other traumatic event, Ib 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Irene Frakes Harold J. Hartley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 st Department of Health ar Important; If item 27 is any injury or other trau 2005. 5020 Paducah Road College Park, Maryland 20740 Frieda H. Hartley -wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 3/2/2004 Silver Spring, Maryland * 4 □Donation 5 □ Other (Specify) 22. Name and Address of Facility
Donald V. Borgwardt Funeral Home, P.A.
4400 Powder Mill Rd. Beltsville, Maryland 20705 21. Signature of Funeral Service Licensee Sorold 23a. Part1. Enter the disease, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Respiratory Physician /Medical Due to (or as a consequence of) carcinoma of Phorynx Examiner Squarrous Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine ng physician and as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy atter for u in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate 1 Yes 2 X No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one, Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Certification: To 1 ☐ Yes 2 X No - 5 Residence 6 Other (Specify) After the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Japitar L.
4 hours after dea.
rat Director; After 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 24 hours a 1) Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the I 29d. Date signed (Month, Dey, Year) February 27, 2004 29b. Signature and title of certifier 29c. License number Ende Mc see, MO D0053840 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Linda McGee, M.D. 13960 Baltimore Blvd. Laurel, Maryland 20707 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 03 2004 Registrar

Months

Gaithersburg

10f. Zip Code

1 Yes 2 No

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Mail Messenger

7. Age (In yrs. last birthday)

73

12. Was Decedent Ever in U.S. Armed Forces?

Year or Dates:

College (1-4or 5+)

Yrs.

10c. City, Town or Location

Type or Print in Black Indelible Ink. Ensure Al	l Copies Are Legible.	
State of Maryland / Department of Health and M	lental Hygiene 2004	08728
Certificate of Death	Reg. No.	
ast)	Date of Death Month Day Year	3. Time of Death
HAMILTON	FEB 26, 2004	5:01 PM

4b. City, Town, or Location of Death

If Under 1 Year If Under 24 Hrs.

Days

Bethesda

Hours

20878

13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Specify:

4c. County of Death

10g. Citizen of What Country?

Specify:

16b. Kind of Business/Industry

GEICO

U.S.A.

14. Race - American Indian, Black, White, etc.

Black

8. Date of Birth (Month, Day, Year) Dec. 13, 1930

18. Mother's Name (First, Middle, Maiden Sumame)

Annie Johnson

MONTGOMERY

9. Birthplace (State or Foreign

10d. Inside City Limits

1 ☐ Yes 2 【No

Maryland

Physician /Medical Examiner 1. Decedent's Name (First, Middle, Las

V.

4a. Facility Name (If not institution, give street and number)

10b. County

Suburban Hospital

12324 Bradbury Drive

15. Decedent's Education (Specify only highest grade completed)

Herbert Sewell

1 □ M 2 □ ₹

Montgomery

MARY

5. Social Security Number

10e. Street and Number

1 ☐ Never Married 2 ☑ Married

3 Widowed 4 Divorced

Elementary/Secondary (0-12)

9th

17. Father's Name (First, Middle, Last)

10a. State

MD

214-28-7523 Usual Residence of Decedent

Funeral Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Physician /Medica Examine

physician and s the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed signed by I After this c funeral dire within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Division of Vital Records, P.O. Box 68760,

14	19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailing Add	dress (Street and No	imber or Rural R	oute Number, City	or Town, State, Z	(ip Code) 2.0878				
	Benjamin R. Ha 20a. Method of Disposition	20b. F	Sb) 123 Place of Disposition cometery, crematory	324 Brad	bury D		thersbu	rg, MD				
	1 Surial 2 □ Cremation 3 □ Re '4 □ Donation 5 □ Other (Specify)		rklawn N	Mem. Pk	3/6/0		ockvill					
	21. Synatura — ineral Service Li sense	Saous		ne and Address of F N. Wash				OME, P.A. 20850				
	23a. Part1. Enter the disease, or complice shock, or heart ailure. List only on	ations that caused the deat e cause on each line.	h. Do not enter the	mode of dying, suc	h as cardiac or re	espiratory arrest,		Approximate Interval Between Onset and Death				
	Immediate Cause (Final disease or condition resulting in death)	End stage Due to (or as a conseq		ic Obstr	uctive	Pulmona	ary Dis					
miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c	Chronic 2 Due to (or as a conseq		Tibrilla	tion							
by Physician/Medical Examiner	resulting in death) Last											
	FFEMALE: 23b. Was decedent pregnant 1											
d by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to to the contribution of the cont											
Completed	Congestive	24a. Was an autopsy performed?	autopsy prior to completion of cause of death?									
Be		26. Place of Death (Check only one)										
To	1 ☐ Yes 2 ☐ No	ospital: Inpatient 2	ER/Outpatient 3	5 🗌 Residence	6 ☐Other (Spec	cify)						
ation:	27. Manner of Death 1 □ Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	t. Describe how inju	ury occurred							
Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, street, f	. Location (Street a City or Town, Stat	nd Number or Ru e)	iral Route Number,						
	29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title-of certifier 29c. License number 29a. Certifier 29b. Signature and title-of certifier 29c. License number 29d. Date signed (Month, Da)											
Z	29b. Signature and title-of certifier			29c. License num	ber	29d. Da	ate signed (Monti	h, Day, Year)				

Date signed (Month, Day, Year) 023170 30. Na san address of pe son who completed cause of death (Item 23a) (Type, Print) 9406 Old Georgetown Rd., Bethesda, MD 20814 Gita Bakshi, M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State **MAR 03** Registrar

State of Maryland / Department of Health and Mental Hygiene? \bigcap \bigcap \bigcup 08729 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 2-27-2004 Year **Physician** 10:18 A M Hubert R. Hamerski /Medical 4c. County of Death 4e. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 01ney Montgomery Montgomery General Hospital If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□F Director 469-18-2211 85 Minn. Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County r then "natural", or Items 23a or 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Silver Spring Montgomery 10g. Cilizen of Whal Country? 10e. Street and Number 10f. Zip Code 20906 USA 3310 N. Leisure World Blvd. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Pension Specialist Insurance pell 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: If Item 27 is marked oth eny injury or other traumatic event once. John Hamerski Frances Poblocki 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cleo B. Hamerski - Wife 3310 N. Leisure World Blvd. Silver Spring, MD 20906 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 □ Donation 5 □ Other (Specify) Gate of Heaven 3-2-04 Silver Spring, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Hines-Rinaldi F. H. Dugue 11800 New Hampshire Ave. Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Immediate Physician Myocardial Infarction /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and the burial-tran Due to (or as a consequence of): Box 68760 Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) o detached 9 Unknown ۵. signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobecco use contribute to the cause of death? Records, þ Acute Renal Failure 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Aortic aneurism repair - abdominal Jas autopsy performed? Hypertension 2 X No 1 Yes 2 No 1 Yes Division of Vital funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Cther: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After or Attending 5 Pending Injury 1 ₩Natural after death. 1 Yes 2 No investigation 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospitel
within 24 hours a
To the Funeral E Hospitei 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medicai completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 10) D17826 2-27-2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAR 01

2004

oakers

Arthur Schoengold, M.D. 18101 Prince Philip Dr. Olney, MD 20832

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 08730 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day **Physician** 3:23 p February 28, <u>John Wade Hayes, Sr.</u> 2004 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 471 Old Orchard Circle <u>Millersville</u> Anne Arundel 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Months 1**⊠** M 2□ F 100-32-2090 New York Director 62 26, 1941 Mar. Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a State 10d. Inside City Limits 10b. County 1 and 2 should be filed within 72 hours atter death with the Marylan Health and Mental Hygiene.
Health and Mental Hygiene.
Health and Mental Hygiene.
Health are marked of the than "natural", or liems 23a or 28a-1 ahow tiem 27b marked to the than "taking the notified at MD Anne Arundel Millersville 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 471 Old Orchard Circle 21108 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ½Yes 2 ☐ No If Yes, Give Year or Dates: Vietnam 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 🔀 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry observation (Give kind of work one during most of working life. DO NOT use retired)

Vice President of Elementary/Secondary (0-12) College (1-4or 5+) Marketing 5+ Air Force/ Military/ AT&T 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Astor Wade Hayes Emilie Shon ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Valita Hayes/Wife item 27 other tra 471 Old Orchard Circle Millersville, MD 21108 March 5 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Importent: If ite
any injury or ott 1 Burial 2 □ Cremation 3 □ Removal from State 2004 West Point, NY * 4 □ Donation _ 5 □ Other (Specify) West Point Academy Cem. 21. Signature of Funeral Service Licenses P.A. Parranco & Sons, P.A. 1495 Gov. Ritchie Hwy. Severna Park Funeral Home Severna Park, MD 21146 Approximate Interval Between Onset and Death 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line. Adenocancinoma Immediate Cause (Final disease or condition Metastatic Colonic **Physician** dispase or condition resulting in death) One Veau /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner that the death certificate be executed burial-trar Due to (or as a consequence of): Physician/Medical the attending IF FEMALE esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy ō Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death ☐Yes 2☐No detached 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ р 2 X No 1 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy performed: certificate 2 No 1 ☐ Yes 2 ☐ No 1 Yes To the Hospitet or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 25 No 1 Inpatient 2 ER/Outpatient 3 DOA ŧ 2 this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c, Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No м death. within 24 hours after death To the Funeral Director: . completely filled in by the f 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Tig Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) North Charles St. Nanghill A.L -69 e ume 65 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 0 4 2004 Registrar

DHMH 17 Rev 1/2001

Maryland 21215-0036

Baltimore,

Box 68760,

P.O.

Division of Vital Records,

(<i>)</i>	1	For State Registrar		State of Ma	aryland / De	epartm Certific	nent of Ho cate of L	ealth and M Death	lental Hy	giene 2 Reg. No.	2004	08731
	" W. L. •			(First, Middle, Last)						2. Date of De	aath Cay	Year	3. Time of Death
	Physicia /Medic		Terry Al	llan Holla	r					FEBRU		2004	2106 PM
	Examin		4a. Facility Name (In	not institution, give s	treet and number)				Location of Death		4c. C	ounty of Deat	h
		2		EECHERS AV		4 / ///		ROSTBU	If Under 24 Hrs.	9 Data of Bi		LEGANY	
	Funeral Director		5. Social Security N 31.5-80-0			e (In yrs. last birtho 36 Yr	Mor	Inder 1 Year onths Days	Hours Min.	8. Date of Bi (Month, Da NOV 7,	1967	Ind	hplace (State or Foreign untry) 1ana
ī	and	-	Usual Residence of 10a. State	Decedent 10b. County		10c. City, Town	or Location	1					10d. Inside City Limits
	death with the Maryland ms 23e or 28e-f show r must be notified at	ğ	MD	Allegany		Fros	tbur	a .					1 ☐ Yes 2 No
	the 1	Funeral Director	10e. Street and Nur					f. Zip Code			10g. Citize	en of What Co	untry?
	3e or	0	17218 Be	echers Av	enue			2153	2		U	SA	
	deati	ner	11. Marital Status		12. Was Decedent Armed Forces?	Ever in U.S.	13. Was I	Decedent of Hi	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No Rican, etc.)	0- 14	4. Race - Ame Black, Whit	
20	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hyglene. If Health and Mental Hyglene relativelt, or Items 23e or 28e-f show item 27 is marked other than "natural", or Items 23e or 28e-f show other traumatic event. The Modical Exemples relative and the notified at	by Fu	1 Never Marr	ied 2⊠ Married 4 □ Divorced	1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:			es 2 No	Specify:				hite
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yland	12 should be filed within "and Mental Hygiene. 7 is marked other than "fraumatic event, tha Men	To Be	Bill Ho						Beverly				
Mary	shou and M s mai			ame/Relationship (Ty					and Number or Rur				
	s 1 and 2 of Health a item 27 Is other tra	1		Ann Holla	r/wife		and the same		Avenue,				
ore	of He		20a. Method of Dis 1 ☐ Burial 2	position ☑ Cremation 3 ☐ P	emoval from State	20b. Place of D cemetery,			1	Date		ation - City or	
Baltimore,	t. Pages nment of ntant: If it njury or o			5 Other (Specify)		Country		e Crem.		2004_	David	dsville	e, PA
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	100		23a. Part1. Enter t	the bisease, or compl art failure. List only of	ications that caused	d the death. Do no	t enter the	mode of dyin	g, such as cardiac	or respiratory	arrest,	II) ELJ	Approximate Interval Between
0.00	Physician		Immediate Cause disease or condition	(Final	Contai	t gunst	rot	wound	d of h	end			Onset and Death
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	cate be executed physician and s the burial-transit	Examiner	that initiated event resulting in death)	s Last	Due to (or as	a consequence of):						
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. Box	that the death certificated by the attending properties as	ician/M	IF FEMALE: 23b. Was deceder in the past 12 1 \(\sum \) Yes 2	nt pregnant 2 months?		of pregnancy 2 Fetal death at time of death		pic pregnancy er (specify)			23	3d. Date of de Month	livery Day Year
P.0	at the d by th etach	Physicia	9 Unknow	ificant conditions co		but not reculting in	the under	vina causa aw	on in Part I	23a Did	tobacco us	e contribute to	the cause of death?
	w requires that been signed be should be det	Ď	Part II. Other sign:	meant conditions co	ntheuting to death i	out not resulting in	are under	Allid cansa div	en in Faiti.		Yes 2	,	robably 4 Dunknown
Vital Records,	B 8 CA	Completed								24a. Wa auto peri 1 [X] Yes	opsy formed?	prior to death?	utopsy findings available completion of cause of
ta		a)	25. Was case refe	rred to medical					26. Place of Dea			- 45.00	
	Physician: r this certific ral director,	To B	examiner? 1X Yes 2 □] No	Hospital:	ient 2 ER/Outr	patient 3	□ DOA Oth	er: 4 Nursing H	ome 5 ☐ Res	sidence 6	XOther (Spe	city) AT SCENE
0 0	ng Phys ter this neral di		27. Manner of Dea	th 5 🗆 Pending	28a. Date of Inj (Month, Di	ury 28b. Ti ay Year) In	ury	28c. Injur Wor	y at k?	28d. Describe	how injury	occurred	0 call
Sio	Attending ir death. ector: After by the fune	cati	2 Accident	investigation 6 Could not be	2-28-				Yes 2 No	Sub	Comment	Shot	ural Route Number,
Division of	or Atl	Certification:	4 Homicide	- determined	huilding e	njury - At home, fari atc. (Specify) at side of		-	OMEO	City or To	own, State)	17218	Beeches Ave
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier (Check only	1☐ Certifying Phy 2☐XMedical Exam	sician: To the bes	t of my knowledge,	death occ	curred at the tir	ne, date and place	and due to the	e cause(s)	and manner a	s stated.
	the H hin 24 the F mplete	Medical	one) 29b. Signature an		and manner s	tated.		29c. Licens				signed (Mon	
	To To Co	-	230. Signature an		. m.D				OCME			_	29, 2004
,				dress of person who c	ompleted cause of								
				MG LI			1 Pe	nn Stre	et, Balt	imore,	Maryl	and 21	201
	St Regist	ate rar	31. Date filed (Mc	MAR -	2 2004 2	trads Signature	B A	forthe					

State of Maryland / Department of Health and Mental Hygien 2004 08732 State
Registrar AMEND#9&10qperFH3/3/04, EMW, McCo Certificate of Death Reg No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Vest **Physician** 7:00 A M Dorothy M. Jordan February 27, 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Shady Grove Hospital Montgomery Rockville If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign County Tinidad Trinadad W. I 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 ☐ M 2 💢 F 90 129-52-8517 26, Trinadad Director 1913 Usual Residence of Decedent with the Maryland 10c. City. Town or Location 10a, State 10h County 10d. Inside City Limits rithen "natural", or Itame 23s or 28s-f show the Medical Examiner must be notified at 1X Yes 2 No Maryland Montgomery Silver Spring Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14538 Macbeth Drive 20906 Trinidad W.I. Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 12 Caregiver Private ages 1 and 2 should be filed vant of Health and Mental Hygient: If Item 27 is marked other? y or other traumatic event, It. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Cecilia Lewis ပ္ Joseph Jordan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Eastlyn Z. McIntyre 14538 Macbeth Dr., Silver Spring, MD (daughter) 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If only injury or once. 3/5/04 * 4 ☐ Donation 5 ☐ Other (Specify) Lapeyrouse Cemetery Port of Spain 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McGuire Funeral Service Show lude 7400 Georgia Ave. N.W., Washington, D.C. 20012 poor 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final ENTEROCOCCAL **Physician** weol disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 6 odce PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, ding physician Physiclan/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months Day Year 5 Other (specify) signed by the a d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ DECUBITUS ULGER. 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 Yes 20 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: 1 ☐ Impatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 No ٩ 3 DOA funeral Manner of Death Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospitel or Attending 5 Pending investigation 1 Yes 2 No death. after death | Director: / d in by the f 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled within 24 hours a To the Funerel C 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and tile of certifier 29c. License number aus D 33224 FEBRUARY 27, 2004. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ram Trehan, M.D. 50 WEst Edmonston Drive #303, Rockville, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 02 2004 Registrar

Funeral

TOSNHOL

STERLING

Examiner Director

permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryle Department of Haalth and Mantal Hyglene.

Department of Haalth and Mantal Hyglene.

Special Functionals is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantreat must be notified at once.

Be Completed by Physician/Medical Examiner physician and is the burial-transit cartificata has been signed liractor, paga 2 should be det

Baltimore, Maryland 21215-0020 Physician /Medical Examiner or Attending Physician: The law raquiras that the death certificate be executed Division of Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funeral Director: After this cartific completaly filled in by the funeral director, Medicai Certification: To

an :al	Sterling a	J. Johnso	on						FEBRU	ARY 28	2001	+ 9-55 Ar
er	4a Fecility Neme (If not institution	n, give street end num	nber)			4	-	_	cation of Dea	th 4c. County	y of Deeth	
	NORTH ARU	ndel H	103pit17	4		(Bur		Anne	· Ar	undel
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	Usuel Residence of Decedent											
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<u>•</u>	10e. Street end Number				10f. Zip	Code				10g. Citizen of	What Cou	ntry?
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Jer.	11. Merital Status	12. Was Dece	dent Ever in U,S.	. 13. V			ispanic Or	rigin? (Spe	ecify Yes or N Rican, etc.)	US o- 14. Rad		can Indian,
Ē	Merried 2 Merri	Armed For ried 1 ☐ Yes					an, Mexica	n, Puerto	Rican, etc.)	Bla	ck, White,	, etc.
To Be Completed by Funeral Director	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	Э	1	I □ Yes	\$€INO	Specify	:		Specif	у:	Black
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ŏ	17. Father's Neme (First, Middle,		asonary			Mase			rker	CONCI		
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۲	Charles Jo					(2)		_		Wallad		
	19a. Informant's Name/Relations									ber, City or Town,		·
	Agnes Coates	(Sister)					Rd.	Seve		ark, Mo		
	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		сел	ce of Dispos netery, crem ente:	natory or c	ther plac		tery	Date 3/5/	04 Rous		own, State ay, Md.
	21. Signature of Funeral Service	Licensee					ss of Facili					
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	shock, or heart failure. List	only one cause on ea	ich line.	Do not ente	er the mod	ie or dyln	g, such as	cardiac o	r respiratory a	arrest,		Approximate Interval Between Onset and Death
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	Immediate Cause (Final disease or condition	. 5	EPS1	5							:	10 DAYS
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cia	Part II. Other significent condition	ne contribution to de-	ith his not receive	ne in the co	aloduis -		an in Day of		not D:	Antibar	 	
YS					derlying c	ause give	en in Parti	i,				o the cause of death?
ompieted by Physician/Medical Examine	CARCINOMI	A OF	LARY	NX					10	Yes 2□ No	3 ∐ Proi	bably 4 ⊡ ∕ Ú nknow
8									24a. Was	an autopsy	24b. W	ere autopsy findings
jet									perfe	ormed?	co	ailable prior to impletion of cause death?
Ĕ									2942			
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25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28d. Describe how injury occurred

28e. Date of Injury (Month, Dey Year) 27. Manner of Death 28c. Injury et Work? 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

29b. Signature and title of certified 29d. Date signed (Month, Day, Year) FEBRUARY

30. Name end address of person who completed cause of death (Item 23e) (Type, Print) M. SHIRAZI, M.D. NORTH ARUNDEL

MD HOSPITAL. 21061.

State Registrar 31. Date filed (Month, Dey, Year) MAR 0 4 2004



		1 - State of Ma	aryland / Depa <i>Cer</i>	artment of Heal tificate of Dea	th and Men ath	ntal Hygie Reg	2004	08734
		Decedent's Name (First, Middle, Last)				Date of Death Month	Day Year	3. Time of Death
Physic /Medi		Nicholas Karas					4 2004	9:35 P M
Exami		4a. Fecility Name (If not institution, give street and number)		4b. City, Town, or Loca			4c. County of Death Anne Arun	.d1
		Anne Arundel Medical Cent 5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday)		napolis	Date of Birth		olece (State or Foreign
Funeral Director		578-48-8283 1\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	66 Yrs.		urs Min.	(Month, Day, Yoct. 9.	ear) Cour	sylvania
D		Usual Residence of Decedent				CC. 7,		
arylan how	-	Maryland Anne Arundel	10c. City, Town or Lo	cation Anna p	olis		1	10d. Inside City Limits
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with the sor 2	Funeral Director	10e. Street and Number 1010 Tallwood Road Apt. TA		10f. Zip Code 214	.03	10g	. Citizen of What Cour	ntry?
leath ne 23	era	11 Marital Status 12. Was Decedent 8	Ever in U.S. 13. V	Was Decedent of Hispani	ic Origin? (Specify	Yes or No-	14. Race - Americ	can Indian,
or its		Armed Forces? 1 □ Never Married 2 ☑ Married 1 ☑ Yes 2 □ N If Yes, Give		f Yes, specify Cuban, Me		ın, etc.)	Black, White,	
ours ours	dby	3 Widowed 4 Divorced Year or Dates: 1	954–61	I□Yes 2⊠No <i>Spe</i>	ecify:		Specity: Whi	
natu natu	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	tent's Usual Occupation kind of work done during DO NOT use retired)	most of working		b. Kind of Business/In	•
withir ene.	E C	Elementary/Secondary (0-12) Coltege (1-4or 5	+)	ge Clerk	•		etropolita ransit Aut	
Hygi other	Be C	17. Father's Name (First, Middle, Last)		18. M	Mother's Name (Fil	rst, Middle, Mai	iden Sumame)	HOLICA
ally failed Z. I.Z. I. 2-0000 should be filed within 72 hours after death with the Maryland and Mental Hyglene. It marked other then "natural", or Itame 23e or 28e-f ehow marked other than Maryland Examinating the incitited at medical Examinating the incitited at the statement of the statement	To B	Harry Jordan Karas		E	Clizabeth	Abrami	des	
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ges 1 and 2 should be filed within 72 hours after death with the Marylan ges 1 and 2 should be filed within 72 hours after death with the Marylan to f Health and Mental Hygiene. If Item 27 is marked other then "natural", or Iteme 23a or 28a-f show or other freumatic event, If a Madical Examinations by notified at		Manny Karas/son	20b. Place of Dispos	Tallwood Ro	Dete		1 7	
permit. Pages 1 and Department of Health Important: If Item 27 any injury or other tr		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	cemetery, crem	natory or other place) ins Cemetery	1.60		c. Location - City or To ownsville,	
permit. Pages Department of Important: If I eny injury or once.		* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 2		. Name and Address of F	1		•	
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		23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin	the death. Do not ente	er the mode of dying, suc	ch as cardiac or res	spiratory arrest	,	Approximate Interval Between Onset and Death
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leath certific attending p	Physician/M	23b. Was decedent pregnant in the past 12 months? 1	2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ery Day Year
that the de led by the a detached f	nysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown	inte of death 30	Other (specify)				
res that igned b	by Pt	Part II. Other significant conditions contributing to death but	it not resulting in the un	nderlying cause given in F	Part I.	23e. Did toba	of use contribute to the	ne cause of death?
A requires been sig	ed b	Congestive Heart	Failu	2		1 Yes	2 □ No 3 □ Prob	ably 4 Unknown
law requ	piet	Chan's cobstructive	Pulman	Asecs	و	24a. Was an autopsy	24b. Were auto	psy findings available mpletion of eause of
The law ate has page 2:	Completed			2		performed	death?	2 No
ysicien: The is certificate his director, page	Be (25. Was case referred to medical examiner?			Place of Death (Ch	neck only one)		
Physician: rthis certificaral director, rall	2	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatie					e 6 Other (Specify	y)
fte fi	tion	1 Natural 5 Pending (Month, Day	y Year) 28b. Time of Injury	28c. Injury at Work? M 1 ☐ Yes		Describe how i	injury occurred	
death death octor:	fica	3 Suicide 6 Could not be 28e. Place of Inju	ury - At home, farm, stre			Location (Stree	t and Number or Rura	I Route Number,
s after	Certification:	4 Homicide determined building, etc	:. (Specify)			City or Town, S	itate)	
To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of 2 Medical Examiner: On the basis of and manner sta	examination and/or inv	occurred at the time, da	te and place, and o	due to the caus t the time, date	e(s) and manner as st and place, and due to	ated. the cause(s)
fo the vithin fo the comple	Me	29b. Signature and title of certifier		29c. License num	nber	29d.	Date signed (Month,	Day, Year)
- S - 0		8-11		D005	8297		3/5/04	_
		30. Name and address of person who completed cause of de	eath (Item 23a) (Type, F	Print)		0	-121-1	A R
		HOWARD YOUNG M	D. An-	e Drumbe	on a	w Ce	uhr, An	napolis M
Sta Regist	ate	31. Date filed (Month, Day, Year) 32. Registra	ur's Signature	locale .				•

ORIGINAL

amend item#Part II,25,PER ME,C832,6/30/04eg
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For State Registrar	State of M	laryland /	Depa Ce	artment <i>rtificate</i>	of He	ealth a Death	and M	ental Hy	giena Reg. No	004	08	735
			1. Decedent's Name (First, Middle, Las	t)							2. Date of De. Month	ath Day	y Year	3. Tim	e of Death
	Physicia /Medic		JUANI	TA R.	KING						FEB.		2004	212	0 M
>	Examin	_	la. Facility Name (If not institution, give	street and number)		4b. City, T	own, or	Location of	of Death		4c.	County of Dea	ith	
			Montgomery				If Under 1		ney If Under	24 Hrs	9 Data of Rie	4b		GOMER	
	Funeral		5. Social Security Number 6. S	9x	ge (In yrs. last 58	<i>Diπnα</i> ay) Yrs.		Days	Hours	Min.	8. Date of Bin (Month, Da	y, Year)	C	ountry)	te or Foreign
	Director	-	213-66-2232 Usual Residence of Decedent		36					[.	Feb.20	J , 15	946]	Maryl	and
	and and	-	10a. State 10b. County		10c. City, To	own or Lo	ocation							10d. Inside	e City Limits
	Mary	ō	MD Monto	omery			Brink	low	,					120	res 2□No
	r 28a	iec	10e. Street and Number				10f. Zip (Code				10g. Cit	izen of What C	ountry?	
	h with	Funeral Director	20011 New Hamp	shire A	venue			208					U.S.A		
	deat deat	ner	11. Marital Status	12. Was Deceden	t Ever in U.S.	13.	Was Decede If Yes, specif	ent of His	spanic Ori	gin? (Spe n, Puerto I	cify Yes or No Rican, etc.)	-	14. Race - Am Black, Whi		١,
9	or ite		1 ☐ Never Married 2☑ Married	1 ☐ Yes 2 ☐ If Yes, Give			1 ☐ Yes 2						Specify:	Black	:
8	72 hours after death with the Maryland netural; or Items 23e or 28a-f show dical Examinatination indiffed at	d by	3 Widowed 4 Divorced	Year or Dates		Ga Daga	dent's Usual	LOggung	tion			16h K	ind of Business	/Industry	
215-0036	net .	Completed	15. Decedent's Education (Specify only highest gra	de completed)		(Give	kind of work	k done d	<i>lurina</i> mos	t of worki	ng	100.10			
_	within ene. than	E C	Elementary/Secondary (0-12)	College (1-40)	r 5+)	Wa	itres	s				Re	staur	ant	
	filed Hygir other ant, I	O	17. Father's Name (First, Middle, Last						18. Mothe	er's Name	(First, Middle	, Maiden	Sumame)		
<u>a</u>	should be find Mental he marked of	To B	James Powell						Ε	Bess.	ie Fis	sher	:		
Maryland	shou ind M ind M iner		19a. Informant's Name/Relationship (Type, Print)	lų.	19b. Maili	ing Address	(Street a	and Numbe	er or Rura	l Route Numb	er, City	or Town, State,	Zip Code)	862
	and 2 ealth a n 27 ls		Thomas M. King	(Husba	nd)	200.	11 Ne	W H	amps	shir	e Ave.	, E	Brinkl	N , W	[D
Baltimore,	of its #		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Bemoval from Stat	com	e of Dispe	osition <i>(Nam</i> matory or oti	ie of her place			ate	20c. L	ocation - City o	r Town, Stat	9
<u><u>Ĕ</u></u>	Page nent c		*4 ☐ Donation 5 ☐ Other (Special	y) /	Bus		Park			3/5/			kesvi		
alt	Departr Departr Import any inj		21. Signature of Funeral Service Lice	the auch	101.								ERAL I		
Φ.	207		Julya V. E	nuna	eu								11e, 1	MD 20 Approxi	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	one cause on each	line.							irest,		Interval	Between ind Death
	Physician		Immediate Cause (Final disease or condition resulting in death)		TRA C		RAC	B	LCE	DIN	6			1 3	40
	/Medical Examiner		leading in dealing	Due to (or a	as a consequent	ice of):	Eno 70	((ALD	OU	SCULA	e D	USTASE	1 71	Sa
		-	Sequentially list conditions,	D. —	as a consequen				710-5						/
	nted I Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events								. //		/		
,	be executed ician and burial-transit	Exa	resulting in death) Last	Due to (or a	as a consequen	ice of):			1	1	ROVED BY ME	OCAL EX	AMINER		
8760,	ate be ex nysician he buria	Ical	(_ d					-	ANN AP	CONED BY WE	Dioles			
9	tifical ng phy as th	led	15.55111.5					-	PERMIT	Thom:					
Вох	eath certifica attending ph I for use as th	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcon 1 ☐ Live birth	ne of pregnancy 2 Fetal de		□Ectopic pre	egnancy					23d. Date of de Month	elivery Day	Year
	ne deal the att	Physician/Med	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant 9□Unknown	at time of deat	h 5	Other (spe	ecify)						,	
P.0	that the de ed by the detached	Phy	Part II. Other significant conditions	antributing to death	but not resulting	no in the	underlying ca	ausa dive	an in Part I	ı	23e. Did	tobacco	use contribute	to the cause	of death?
ŝ	eg pe	by	Part II, Other significant conditions	A RUSA	-	19 11 110	andonying o	2000 g			10	Yes 2	. □ No 3 □ F	Probably 4	Minknown
9	w requir been si should	etec		1,720							24a. Was	: 20	24h Were	utonsy findi	ngs available
Sec.	The law ate has t page 2 s	Completed									auto perfe	psy ormed?	prior to death?	completion	of cause of
al F			GC 1Man and another modified	T					OC Plan	a of Dooth	1 Tes	2 17 No	1 Ye	s 21366	
\ <u>₹</u>		o Be	25. Was case referred to medical examiner?	Hospital: 1	atient 2 TER	VOutpatie	ent 3 DO	Oth	or				6 ☐Other (Sp	ecify)	
ō	ig Phys ter this neral di	2:	27. Marmer of Dath	28a. Date of li		3b. Time		8c. Injun Worl			28d. Describe	_		,,	
on	nding th. r: After e funer	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigate		Day (ear)	Injury	М		Yes 2 □	No No					
Division of Vital Records,	Attandler death	Certification:	3 ☐ Suicide 6 ☐ Could not lead to determine determined	289. Flace 0	Injury - At home etc. (Specify)	e, farm, s	treet, factory	, office			28f. Location City or To		nd Number or I e)	Rural Route	Number,
	s after sale or all Dir	Cer													
	To the Hospitel or Attant within 24 hours after death To the Funaral Director: completely filled in by the	edical	(Check only 2 Medical Exa	hysician: To the be miner: On the basi:	s of examination	edge, dea n and/or i	ith occurred a nvestigation,	at the tin , in my o	ne, date ai pinion, dea	nd place, ath occurr	and due to the ed at the time,	cause(s , date an	 and manner and place, and di 	as stated. Je to the cau	se(s)
	To the I within 2. To the I complet	Med	one) 29b. Signature and title of certifier	and manner	stated.		290	. Licens	e number			29d. Da	ate signed (Mor	nth, Day, Ye	ar)
	To Vit			I/ post	>			DO	50	574	5	5	1/20	7/28	04
	V		30. Name and address of person who	completed cause of	of death (Item 3	3a) (Type	Print)	EX	- C1157	[N	0-	OKI	351 , m	9	1
			30. Name and address of person who	Fruns li	~ Ave		alca	a	Parc	ia	2	090	2		
	St	ate	31. Date filed (Month, Day, Year)	32. Reg	istrar's Signatur	e 4	1	n V	1/						
	Regist		MAR 0 4 2	004	never	1	pape								

Physic /Medi		1. Decedent's Nar	ne (First, Middle, La	ast)					-		2. Date of Dea			3. Time of Dea
AMEGI		Gary Wa	yne Keats	5						_ N	Month March 8	Day 2004	Year	3:37 P.
Exami			(If not institution, gir Grove Roa	ve street and numbe d	or)			Town, or ODSV:	Location of ille	Death			nty of Death	ore
Funeral Director		5. Social Security 216–80–9	9493	Sex 12XM 2□F	Age (In yrs. 39	(ast birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	4 Hrs. Min.	8. Date of Birth (Month, Day Dec. 3	1964	9. Birth Col	nplece (State or Fountry)
death with the Maryland ims 23s or 28s-f show fround by notified at	tor	Usual Residence 10a. State MD	10b. County Anne A	rundel	10c. Ci	ity, Town or Loc		Annap	olis	-				10d. Inside City Li 1 ☐ Yes 2 2
with the 3a or 28a 1 by noti	i Director	10e. Street and N	umber ceenway D	rive			10f. Zip	Code 214	.01	-		l0g. Citizen o	of What Cor	•
a within 72 hours after death with the Marylan jiene. rithan "neturel", or Items 23a or 28a-f ehow triban "neturel", or Items 23a or 28a-f ehow triban he institlied at the Madical Expressional by institlied at	by Funeral	11. Marital Status 1 ☐ Never Ma	rried 2 Married	12. Was Deceder Armed Force 1 Yes 2 If If Yes, Give Year or Dates	s? XNo		Vas Deced Yes, spec	dent of His cify Cubar		in? (Spec Puerto R	ify Yes or No- ican, etc.)		lace - Amer llack, White	rican Indian,
within 72 ho iene. • than "netu the Medical	Completed	(Spe Elementary/Sec	15. Decedent's E ecify only highest gi condary (0-12)		or 5+)		ent's Usua kind of wor OONOT us	rk done d se retired)	uring most	of workin	g	16b. Kind of		ndustry uction
be filed tal Hyg d othe	To Be Co		(First, Middle, Las Emmett	t)							(First, Middle, s Taylo		ame)	
マキなこ			Name/Relationship S Shuey/M	· •							Route Numbe nnapoli			
Pages 1 an nent of Heal int: If item 2 iry or other				□Removal from Stat	ra I	Place of Dispos cemetery, crem en Have) P		12,	20c. Locatio Glen		Fown, State
permit. Pages Department of h Important: If ite ony injury or of		21. Signature	uner I Servi - Lice	2		B 4	Name an arrar 95 GC	Address	s of Facility Sons Ritchi		200.4	erna Pa erna Pa	ark Fi	uneral Ho MD 21146
Medical Examiner	Examiner	disease or condit resulting in death Sequentiatly list of any, leading to cause. Enter Unic Cause (Disease that initiated even	, (b. Due to (or a	as a consec		EUR	uic) i	HUXIC	aciui				
ate be executed hysician and the burial-transit	ical	Cause (Disease of that initiated even resulting in death	or injury ts) Last	c. Due to (or a	as a consec									
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inding Physician: The Taw requires that the death certificate ath. rr: After this certificate has been signed by the attending physical functor, page 2 should be detached for use as the	To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decede in the past 1 1 Yes 2 9 Unknow Part II. Other sign	ent pregnant 2 months? 10 No molificant conditions erred to medical No molifications to Pending Investigation of Could not the condition of the could not th	Due to (or a d. 23c. If yes, outcon 1 Live birth 4 Pregnant 9 Unknown contributing to death Hospital: 1 Inpa 28a. Date of Informacy (Month, 1 on the death of Informacy) 28e. Place of Informacy) 28e. Place of Informacy	ne of pregn 2 Fete at time of ce in but not res attient 2 injury 3ay Year) 64 Injury - At h	quence of): lancy al death 3 death 5 sulting in the un 28b. Time of found: 30	Other (sp	ause give Othe Bo. Injury Work	26. Place c	sing Hom 28 0 1	1 Yi 24a. Was a autops perfort 1 Yes (Check only or e 5	bacco use co	Month 3 Pro D. Were autoprior to clearly 1 Zes Other (Specurred	the cause of death obably 4 Munkm ropsy findings avaiompletion of cause 2 No
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		1- For AMEND #I PER Registra AMEND #I PER Registra AMEND #I PER Registra AMEND #I Spering 3	ype or Print 1 State of MPa PHY G830 4/ 3/8/04, BWW, Mc	rMaridH/ [19/04 JH	配向affin Certific	ént2BH	ealth And	Mental Hygi	iene 19. No.	2004	08737
Physic /Med		1. Decedent's Name (First, Middle, Last, Louise Derethy Kul	oier DOROT	HY LOUIS			-1	2. Date of Death Month February	Day 7 27	Year 2004	3. Time of Death 11:58 P ^M
Exam	iner	4a. Facility Name (If not institution, give		1		•	r Location of Deat	h		County of Deat ntgomen	
Funora	1	Shady Grove Advent 5. Social Security Number 6. Se	7. Age	(In yrs. last bir	thday) If Ur	Rockvi der 1 Year	If Under 24 Hrs				hplace (State or Foreign untry)
Funera Directo		215-20-4157 Usual Residence of Decedent]м 2 X 1 F	78	Yrs. Mont	hs Days	Hours Min.	May 9,	192	5 Mai	ryland
rylanc how		10a. State 10b. County		10c. City, Town	n or Location		•				10d. Inside City Limits 1 ☐ Yes 2 \ No
Ba-f s	Director	Maryland Montgom	ery	Beth	nesda						
with th	Dire	10e. Street and Number			10f	Zip Code		10		en of What Co	untry?
s 234	erai	10003 Dickens 11. Marital Status	12. Was Decedent E	ver in U.S.	13 Was D	20814		Specify Yes or No-		USA 4. Race - Ame	rican Indian.
perfullible, Intellylating A.1. 1-0000 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Nental Hygiene. Important: If item 27 is marked other than "natural", or Items 23e or 28e-f show any injury of other traumetic event, the Medical Exprise must be partitled.	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:			specify Cuba s 2 No	an, Mexican, Puer Specity:	Specify Yes or No- to Rican, etc.)		Black, White Specify:	
2 hou	ted	15. Decedent's Edu (Specify only highest grad	cation	16a.	Decedent's I	Jsual Occup	ation during most of wo	rking 1	16b. Kin	d of Business/	
Med T	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	-)	ife. DO NO	T use retired	d)				
I C. I	S	17. Father's Name (First, Middle, Last)	1		Music	Teach					isic Studio
d be find he cod out	Be C						Doroth	me (First, Middle, M Wolfe y Wolf	10071 6	onnamo)	
Sho k	ုင	Floyd A. Ball 19a. Informant's Name/Relationship (7)	rpe, Print)	19b	. Mailing Add	ress (Street		ural Route Number,	City or	Town, State, Z	Zip Code)
IVIC nd 2 : alith ar 27 is r trau		Pam Lamarra/Daugh	ter	51	l Wooda	acre L	n, PALM	PCOAST FL	321	64	
item item cothe	The .	20a. Method of Disposition		20b. Place of	Disposition ,	Name of or other plac			20c. Loc	ation - City or	Town, State
Page Page	2	1 ☐ Burial 2 【A Cremation 3 ☐ F 1 ☐ Donation 5 ☐ Other (Specify)		Loude	on Parl	c Crem	atory Ma	r 3, 2004	В	altimor	ce, MD
Description Permit. Pages Department of mportant: If it iny injury or o		21. Signature of Funeral Service Licens	ee A = 1/					nes-Rinal			
0 20E	a	alliane la	Coppel	er						r Sprin	ig, MD 20904
Physiciai /Medica	il	23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	ne cause on each line a. Due to (or as a	iratio	n		CM of C		est,		Approximate Interval Between Onset and Death
Examine		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a	consequence	of):						
ite be executed ysician and ne burial-transit	icai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence	of):						
that the death certificate ed by the attending phys detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at the 9 Unknown	Fetal death	3 □Ectop 5 □ Othe	ic pregnancy (specify)	y		23	3d. Date of deli Month	ivery Day Year
law requires that the as been signed by the 2 should be detached.	þ	Part II. Other significant conditions co	ntributing to death bu	t not resulting in	n the underlyi	ng cause giv	ven in Part I.		acco us		the cause of death?
	Completed							24a. Was an autopsy perform	y	prior to death?	topsy findings available completion of cause of
I VICAL IN Iysician: The lis certificate h director, page	Be C	25. Was case referred to medical examiner?					26. Place of De	ath (Check only one			
OT V Physic this ce	2	1 ☐ Yes 2 XNo	Hospital: 1 ☐ Inpatier			DOA Oth	4 🔲 Nursing r	Home 5 Reside	_		cify)
anding Ph anding Ph ath. or: After th	ation:	27. Manner of Death To Natural 5 Pending	28a. Date of Injun (Month, Day		Time of njury M	28c. Injur Wor 1 🗆	ry at rk? Yes 2 □ No	28d. Describe ho	w injury	occurred	
UNISION OF VITA To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certific completely illied in by the funeral director.	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju building, etc.	ry - At home, fa (Specify)	irm, street, fa	ctory, office		28f. Location (Str City or Town		Number or Ru	iral Route Number,
To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29a. Certifier Check only one) Check only one) Check only one)	sician: To the best o iner: On the basis of and manner stat	examination an	e, death occu id/or investiga	rred at the til ition, in my c	me, date and place opinion, death occi	urred at the time, da	ate and p	place, and due	to the cause(s)
To the vithin To the compl	Σ	29b. Signature and title of certifier	Cyvein			29c. Licens	7093	29 F	e by	signed (Month	n, Day, Year) 28 / 2004
		30. Name and address of person who c	ompleted cause of de	ath (Item 23a)	(Type, Print)	1 Me	dical Co	enter Driv	14	Rodevil	U MD 2085
	State	31. Date filed (Month, Day, Year) MAR 0 4 200	32. Registra	r's Signature	4 d	oaks					

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2006 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** March 2004 12:20PM Margaret Alagia Kaplow /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Howard Ellicott City Morningside House If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 21, 1927 Birthplace (State or Foreign Country)
 Maryland 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Months Days Hours 1 □ M 2 1 F 76 217-24-3784 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event. Its Modical Examinar must be notified at Ellicott City 1 Yes & No Maryland Howard Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5330 Dorsey Hall Drive #223 21042 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes ZXNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed by 3℃Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be fill timent of Health and Mental H tent: if item 27 is marked ott jury or other traumatic even Be Lorenzo Alagia Mildred Watson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) M. Constance Siegel/daughter 3610 Paul Harris Ct. Ellicott City, MD 21042 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. Old Bohemia Cemetery 3/4/2004 Warwick, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) permit. 21. Signatur - uneral/ er ice Licensee 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Advanced COPD **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Hypertension Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical the use as 1 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy tor in the past 12 months? Month Dav 4 Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş eq. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 反Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s certificate has autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No Attending Physicien: 25. Was case referred to medical funeral director 26. Place of Death (Check only one) Be Assisted Living Cther: 4 Nursing Home 5 Residence 6 Other (Specify) Facility Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 🍇 No Medical Certification: To this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Natural 5 Pending Injury 1 TYes 2 🗌 No • Funerel Director: A letely tilled in by the fu death. investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide ō the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely To the 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifie D 50870 March 2, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5005 Signal Bell Lane Dr. Suzan Abdo Clarksville, MD 21029 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 03 Registrar 2004 & front

ORIGINAL

		1 - State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artment of Health and rtificate of Death	Reg	ene 2004	08739	
Physici /Medio		Decedent's Name (First, Middle Marie	, Last) Rosie	1	Klima	2. Date of Death Month Februar	Day Year	3. Time of Death	
Examir		4a. Facility Name (If not institution	, give street and number)		4b. City, Town, or Location of De		4c. County of Death		
		WILLIAM HILL			EASTON		TALBOT		
Funeral Director		5. Social Security Number 218-01-2373	. C	e (In yrs. last birthday, Yrs.	If Under 1 Year If Under 24 H Months Days Hours N	Ain. 8. Date of Birth (Month, Day, Y	(ear) 9. Birthplace Country) MARYL	AND	
filed within 72 hours after death with the Maryland Hygiene. Hygiene. other then "naturel", or Hems 23e or 28e-f show ent, the Modified at ent, the Modified Examination of the modified at		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Le	ocation		10d.	Inside City Limits	
or 28e-f show	ē	MD T	ALBOT	EASTON				1 X Yes 2 ☐ No	
128	rec	10e. Street and Number			10f. Zip Code	100	g. Citizen of What Country?	?	
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"naturel", or Nems 23e or 28e-f shov officel Examitment must be multified at	by Funeral Director	3 ☐ Widowed 4 ☐ Divorced If Yes, Give 1 ☐ 1 ☐ 1 ☐ 1 ☐ 1 ☐ 1 ☐ 1 ☐ 1 ☐ 1 ☐ 1			Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pt 1 ☐ Yes 2 ☒ No Specify:	? (Specify Yes or No- uerto Rican, etc.)	14. Race - American Black, White, etc. Specify: WHITE	Indian,	
icel t	ted	15. Decedent	's Education	16a. Dece	dent's Usual Occupation	unrting 16	Bb. Kind of Business/Indust	try	
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natic	٦ و	VINCENT KLEMEN		405 14-11		LUDMILLA K		4.1	
neu	Ř Ý	19a. Informant's Name/Relations			ng Address (Street and Number or			œ)	
any injury or other	1 3	GERALDINE L.R 20a. Method of Disposition	. HOUCK/NIEC	20b. Place of Disp	CARROLL RD. GLI		MD 21060 oc. Location - City or Town,	State	
y or		1 ☐ Burial 2 X Cremation 4 ☐ Donation 5 ☐ Other (S			matory or other place)	2 20 2004	COUNTY	B MD	
E a		21. Signature of Funeral Service		the second secon	E CREMATION CTR 2. Name and Address of Facility	2-29-2004	STEVENSVILL	E, MD	
eny	M .	A >	~ FRAS		ELLOWS, HELFENBE			ME PA	
		23a. Part1. Enter the disease, or	complications that caused	the death. Do not en	00 S. HARRISON Ster the mode of dying, such as care	diac or respiratory arres	t. Ap	proximate	
ian		shock, or heart failure. List Immediate Cause (Final	only one cause on each II	ne.	hower akstru	11/104		erval Between aset and Death	
cal		disease or condition resulting in death)	Due to for as	a consequence of):	wowe gasias	werent rou	cua S.	econds	
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	E	resulting in death) Last	Due to (or as	a consequence of):					
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	/Me	IF FEMALE:	23c. If yes, outcome	of pregnancy			23d Data of dollars		
	lan	23b. Was decedent pregnant in the past 12 months?		2 Fetel death 3	☐Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day	y Year	
	Physiclan/M	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown						
		Part II. Other significant condition	ons ¢Gntribปีting to death b	out not resulting in the u	inderlying cause given in Part I.	23e. Did toba	cco use contribute to the ca	ause of death?	
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	mo				E	autopsy performe	d? death?	etion of cause of	
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	To B	examiner? 1 Tes 2 Tho	Hospital: 1 Inpatie	ent 2 ☐ ER/Outpatie			ce 6 ☐Other (Specify)		
		27. Manner of Death 1 △Natural 5 ☐ Pendin	28a. Date of Inju (Month, Da	y Year) 28b. Time o		28d. Describe how			
	atle	2 ☐ Accident investig	gation		M 1 ☐ Yes 2 ☐ No				
	Certification:	3 ☐ Suicide 6 ☐ Could I 4 ☐ Homicide determ	ined 200. Flace of Inj	ury - At home, farm, st c. (Specify)	reet, factory, office	28f. Location (Stre City or Town,	et and Number or Rural Ro State)	oute Number,	
	edical			f examination and/or in	th occurred at the time, date and playestigation, in my opinion, death o				
completely titled in by the funeral director, page z snould be detached for use a	Σ	29b. Signature and title of certifie.	00	1.1-00	29c. License number	290	. Date signed (Month, Day,	, Year)	
		· W	lliam 1	(noor)	1008	115	2/24/09		
		30. Name and address of person	who completed cause of c	leath (Item 23a) (Type,	Print)		, / (
					MANS LANE EASTON	N, MD 21601			
Sta		31. Date filed (Month, Day, Year)		ar's Signature	1				
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			otate or many tand or	Certificate of	Death	R	eg. No. 200	4 08740			
	Physicia		Decedent's Name (First, Middle, Last) WADE M. KIPP			2. Date of Deel Month 03-04	h	3. Time of Death			
)	/Medic Examin		4a Fecility Name (If not institution, give street and number)		4b. City, Town, or Lo		4c. County of De				
_			Allegany County Nursing Home 5. Social Security Number 6. Sex 7. Age (In yrs. last bir	nthday) If Under 1 Year	Cumberlar		Allegan	y irthplace (State or Foreign			
	Funeral Director		47744 00 5	Yrs. Months Days	Hours Min.	8. Date of Birth (Month, Dey, 08-19-1		Country)			
	ylend		10a. Stete 10b. County 10c. City, Tow	n or Location				10d. Inside City Limits			
	a Mar	cto	PA Bedford Hyndm	an				1 ☐ Yes 2 ☒ No			
	vith the	Dire	10e. Street end Number	10f. Zip Code		1	0g. Citizen of What 0	Country?			
	eath v	eral	2110 Hyndman Road 11. Marital Status 12. Was Decedent Ever in U.S.	15545 13. Was Decedent of F	lispanic Origin? /Spe		USA 14. Race - An	perican Indian			
Baltimore, Maryland 21215-0020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylend Department of Heatth end Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Xes 2 No If Yes, Give Year or Dates: 42 - 45	If Yes, specify Cub	Specify:	Rican, etc.)	Black, Wh	nite, etc.			
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ary	s mar		19a. Informant's Name/Relationship (Type, Print)	. Mailing Address (Street			City or Town, State,	Zip Code)			
Σ.	and 2 eaith n 27 I			. O.Box 665,							
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Ba	permi Dapa Impo any Ir		2 - Leigh	Harvey H.	Zeigker F			lman, PA			
	HOB		23a. Fig. 1. Enter the disease, or complete in sthat caused the death. Do shock, a head failure it is a rine lause on each line.	not enter the mode of dyir	ng, such as cardiac o	r respiratory arre	est,	Approximate Interval Between Onset and Death			
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ž.	Examiner		immediate Cause (Final disease or condition resulting in death) a. ASPIRATION Due to (or as a	consequence of):	AINO			ONE MOBITE			
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ot	Attending Physician: or death. ector: After this certific. by the funeral director,	<u>۵</u>	1 ☐ Yes 2 ☑ NO 1 ☐ Inpatient 2 ☐ ER/Ou		442 Nursing Hor		nce 6 Other (Sp winjury occurred	ecify)			
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Division of Vital Record	r Attendi ter death. rector: A	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, fa building, etc. (Specify)	rm, street, factory, office	2	28f. Location (Sti	eet and Number or F , State)	Rurel Route Number,			
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	To the Hospital or Attending Physician: The lav within 24 hours efter death. To the Funeral Director: After this certificate has completely filled in by the funeral director, pege 2		29b. Signature and title of certifier	29c. Licens	e number	29	d. Date signed (Mor	ith, Day, Yeer)			
	6		Mobustians J. Danes.	0-	14865	1	MARCH C	TH 2004			
	In LS		30. Name and address of person who completed cause of death (Item 23e) ((Type, Print)	1		7				
	-		Robustiano Barrera, Memorial Hosy 31. Date filed (Month, Day Year) 32. Registrar's Signature,	rital Medica	l Building	g, Cumbe	rland, MD	21502			
	Stat Registra		MAR 0 8 2004	Sporks							

State of Maryland / Department of Health and Mental Hygienes 08741 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day 2004 **Physician** Elizabeth March 4, Evelyn Kerns /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Sacred Heart Hospital Cumberland If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 1 F Yrs 05/23/1926 Director 215-20-5227 Maryland Usual Residence of Decedent within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show s 23e or 28a-f shows the second secon Cumberland 1 ☐ Yes 2 No Director MD Allegany 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 USA 11218 Brown Hill Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? ir than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Completed by 3 XWidowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) marked other than College (1-4or 5+) Homemaker Homemaker traumatic event, permit. Pages 1 and 2 should be file Department of Health and Mental Hy importent: if item 27 is marked other any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Evelyn Robert William Weaver Marie Flowers 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12913 Bowling Street, SW., Cumberland, MD 21502 Barbara Lantz/ daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 □ Donation 5 □ Other (Specify) Cumberland Crematory 03/07/2004 Cumberland, MD 21. Signature of Fune al Service Licensee 22. Name and Address of Facility Adams Family Funeral Home, P.A. 404 Decatur Street, Cumberland, MD 10-lu 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heer failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 1 hr 45 min Narcotic Overdose /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of) Physicien: The law requires that the death certificate be executed physicien and the burial-transit Exami Due to (or as a consequence of): Physician/Medical as IF FEMALE: esn 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 | Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No ò Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown ģ signed I i be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Carcinoma of the Lung, COPD 1 Yes 2 No 3 Probably 4 Unknown as been si Completed Pancytopenia, CVA 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? page certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No funeral director Be 25. Was case referred to medical 26. Place of Death (Check only one) aminer? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA 1 Yes 2 □ No 2 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred Patient given too much Alter or Attending 1:30 P M 1 Natural 5 Pending 03/04/2004 1 ☐ Yes 2 ☐No investigation hours after death. 2XAccident medication the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Room 340-Sacred Heart Hospital Seton Drive, Cumberland, MD within 24 hours a To the Funerel C Hospitel Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical pletely (Check only 29b Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) COT 4 D09157 March 5, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nes Paul W. Snow, M.D., 124 West Third Street, Cumberland, MD 31. Date filed (Month, Day, Year) NAR 0 5 2004 32. Registrar's Signatur State ocks Registrar

Maryland 21215-0036

Baltimore,

P.O. Box 68760,

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 004 08742 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** February 23, 2004 Lva11 9:10 A. William Edward /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Potomac Valley Nursing Center Montgomery Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 X M 2 □ F 102-22-6146 83 1920 Canada Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. 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Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Photographer Museum 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other treumetic events. Herbert Lyall Annie Hope ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9402 Amboy Road Montgomery Villa e, Md. 20886 Eleanor Semsey Lyall (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Feb 2004 26, 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crem. Alexandria, Va. 22. Name and Address of Facility DeVol Funeral Home 21. Signature of Funeral Service Lice 10 East Deer Park Dr. Gaithersburg, Md. 20877 wells 23a. Part1. Enter the disease, or complic this sthat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pulmonary Embolism **Physician** /Medical Due to (or as a consequence of): Examiner Septicemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Hypertension Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Certification: To Be Completed by Physician/Medical IF FEMALE: . If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Depression page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2X No 1 ☐ Yes 2 ☐ No filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Injury 5 Pending 1 X Natural 1 ☐ Yes 2 ☐ No investigation death 2 Accident after death Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide 24 hours a 29a, Certifia 🎇 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical within 24 ho To the Fune completely fi (Chark only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier -SHAMIM D-59284 February 24, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Shahid Shamim M.D. 1299 Lamberton Drive Silver Spring, Md. 20902 31. Date filed (Month, Day, Year) 32. Registrar's Signature State ouks MAR 0 1 2004 Registrar DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene, 08743 004 For State Registrar Reg. No. Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) MARCH 2004 **Physician** 5:00 P M Ρ. LEWIS YALE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** MONTGOMERY Sandy Spring 17505 Norwood Road | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Dec. 9, 1927 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Wash. 76 DC 577-40-0348 Director Usual Residence of Decedent 10c. City, Town or Location with the Maryland 10d. Inside City Limits 10a. State 10b. County or than "naturel", or items 23a or 28a-f ehow the Medical Examinar must be redified at Yes 2 □ No Sandy Spring Montgomery Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20860 U.S.A. 17505 Norwood Road death v Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. Yes 2 No filed within 72 hours after 1 ☐ Never Married 2 Married Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: Completed by Year or Dates unknown 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Free Lance Broadcaster Communications permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier Important: If Item 27 Is marked other training or other traumatic event, the once. yr 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Ella Williams Roosevelt Lewis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Marie A. Kisner (Wife) 17505 Norwood Road, Sandy Spring, MD 20860 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State Norbeck Mem. Park 3/9/04 Olney, MD 5 Other (Specify) 4 Donation 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 21. Signetars of Funeral Service Licensee 246 N. Wash. St., Rockville, MD 20850 EX 23a. Part1. Enter in a disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hand failure. List only one cause on each line.

Immediate Caus Final disease or condition Onset and Death Physician disease or condition resulting in death) Carcinoma of the Larynx /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, it any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a gonsequence of certificate be executed Due to (or as a consequence of): burial-1 Box 68760, attending physician for use as the buria Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Ö detached 9 Unknown þ ۵. signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ Deep Vein Thrombosis 1 ☐ Yes 2 ☐ No 2 Probably 4 □Unknown ted Deen 24b. Were autopsy findings available prior to completion of cause of death? Complet 24a. Was an Hypertension page 2 autopsy performed? Yes 2 No 1 Yes 2 No 1□ Yes Carcinoma of the Lung, 2000 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 3 DOA 2 funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: After Division 5 Pending 1X Natural 1 ☐ Yes 2 ☐ No al or Attendir s after death. I Director: Af investigation 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ATT ENDING 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of certified oher D34740 MARCH 3, 2004 12 PHYSI CLAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OLNEY, MD 20832 DRIVE # 200 PHILLP 18109 GRINCE ROBERT FIELDS, MA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

MAR 05

			Please I - For State Registrar	State of Mar	yland / Depa		lealth and M	Mental Hygi	_				
			Registrar 1. Decedent's Name (First, Middle, Last)		- 00	illicate of	Death	2. Date of Death		3. Time of Death			
	Physici /Medic	an	Arthur Albert	Leis				Month March	2, 2004	12:45 AM			
	Examin		4a. Facility Name (If not institution, give s Mariner Health of		pring		r Location of Death Spring		4c. County of De				
	Funeral Director		5. Social Security Number 6. Sex 060-10-4148	- A C C C	(In yrs. last birthday) 93 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Nov. 11,	Year) 9. 8 1910 N	irthplace (State or Foreign Country) New York			
	show del	_	Usual Residence of Decedent 10a. State 10b. County Maryland Montgome		ry Silver Spring								
	with the M a or 28a-f be notifite	Funeral Director	10e. Street and Number 1205 Burton Stree			101. Zip Code 20910			10g. Citizen of What Country? United States				
	s 23	ral		12. Was Decedent Ev	ver in IIS 13	Was Decedent of H	lispanic Origin? (Sc	acify Vas or No-	14. Raca - An	nerican Indian,			
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itams 23a or 28a-f show important: If item 27 is marked other than "natural", or itams 23a or 28a-f show any injury or other traumatic event, the Medical Examinal must be multibut at once.	þ	11. Maritaf Status 1 Never Married 2 Married 3 X Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		If Yes, specify Cub 1 ☐ Yes 2 💢 No	tispanic Origin? (Sp an, Mexican, Puerto Specity:	Rican, etc.)	Bfack, Wh				
21215-0036	in 72 ho n *natural	Completed	15. Decedent's Edu (Specify only highest grade	completed)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most of work	sing 1	6b. Kind of Busines	ss/Industry			
12	with than	E	Efementary/Secondary (0-12)	Coflege (1-4or 5+)		Bankin	g		Ban	k			
9	filed Hygi ther		17. Father's Name (First, Middle, Last)					e (First, Middle, N	faiden Sumame)				
an	d be ental	To Be	George Leis Amelia Buhler							£			
Maryland	d 2 shoul th and Me ?7 is marl traumati	F	19a. Informant's Name/Relationship (Ty George R. Leis (S		19b. Mail 120	ng Address (Street)5 Burton	and Number or Rui	ral Route Number, ver Spri	City or Town, State	, Zip Code) 0910			
Baltimore,	ages 1 and of Heal		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	Dc. Location - City or Town, State Beltsville, Md.									
Baltir	permit. Pag Department Important: any injury once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, Md. 20910										
	Physician /Medical Examiner	er	23a. Part. Ente the disease, or complishock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to mineral at the conditions.	Respiration Due to (or as a Pneumon:	tory Fails consequence of):	ter the mode of dyll	ng, such as cardiac	or respiratory arre	ist,	Approximate Interval Between Onset and Death			
68760,	cate be executed obysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	Due to (or as a	consequence of):								
O. Box	res that the death certificate igned by the attending physic be detached for use as the t	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	3c. If yes, outcome o 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death 3	□Ectopic pregnanc □ Other (specify)	у		23d. Date of c Month	delivery Day Year			
ds, P	equires that sen signed b	by	Part II. Other significant conditions con Dementia	ntributing to death but	not resulting in the	underlying cause gr	ven in Part I.		tobacco use contribute to the cause of death? Yes 2 □ No 3 □ Probably 4 ☑Unknow				
Records,	e law r has be je 2 sh	Completed						24a. Was ar autops perform	y prior t ned? death	autopsy findings available o completion of cause of ?			
	ician: Th certificate ector, pag	Ö	25. Was case referred to medical				26 Place of Dea	th (Check only one	21	65 20 110			
of Vital		8	examiner?	Hospital:	t 2 ER/Outpatie	ent 3 DOA Ott	200	Introduction (Check only one) Introduction (Specify)					
of	Phys or this oral di	1; To	27. Manner of Death	28a. Date of Injury	28b. Time		21	28d. Describe ho		boony			
Division	ttending F death. ctor: After y the funer	Certification:	1 Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	(Month, Day	Year) Injury y - At home, farm, s	M 1	Yes 2 □No	28f Location /St	28f. Location (Street and Number or Rural Route Number,				
Div	itsl or A irs after ral Directed in by	Certif	4 Homicide determined	building, etc.	(Specify)			City or Town	, State)				
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exami	sician: To the best of ner: On the basis of and manner stat	examination and/or i	th occurred at the tinvestigation, in my	me, date and place opinion, death occu	, and due to the ca rred at the time, da	iuse(s) and manner ate and place, and d	as stated. lue to the cause(s)			
	To the within To the Comp.	M	29b. Signature and title objection	USS	78	29c. Licen. D4.5	se number 5471	25	March 2	•			
10			30. Name and address of person who con Negussie, M		ath (ftem 23a) (Type Spring St	Print) Silve	r Spring,	Md. 2091	0				
	St	ate	31. Date filed (Month, Day, Year)	32. Registra		,							

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.2 2. Dete of Death 1. Decedent's Name (First, Middle, Lest) **Physician** FEBRUARY 27, 2004 12:30 A.M. JULIA C. LEBEDUN /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Locetion of Deeth 4c. County of Deeth Examiner MONTGOMERY HEBREW HOME OF GREATER WASHINGTON ROCKVILLE If Under 1 Year If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. lest birthday) **Funeral** 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days 1 ☐ M 2 💢 F Director 08/01/1912 PENNSYLVANIA 131-36-3213 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rthan "natural", or Items 23a or 28a-f shover the Medical Examinar reast be notified at 1 X Yes 2 □ No Directo ROCKVILLE MARYLAND MONTGOMERY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20852 U.S.A. 6121 MONTROSE ROAD Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Item any injury or other traumatic event, the Medical Exercit 1 □ Never Married 2 □ Married 1 ☐ Yes 2 🏹 No If Yes, Give Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Š 3 X Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) REGISTERED NURSE NURSING 2+17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be QUIER CORA TINE OBADIAH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10642 MUIRFIELD DR., POTOMAC, MD 20854 HARRY E. LEBEDUN/SON 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/29/04 HEBRON CEMETERY FLUSHING, NY 22. Name and Address of Facility
EDWARD SAGEL FUNERAL DIRECTION, INC. 21. Signature of Funeral Service Licenses 1091 ROCKVILLE PIKE, ROCKVILLE, MD 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** · CHRONIC OBSTRUCTIVE LUNG DISEASE Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physiclan/Medical Examiner been signed by the attending physician and should be detached for use as the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the ceuse of deeth? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown NEUMONIA þ of Vital Records, page 2 should be 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? this certificate has 1 ☐ Yes 2 ☐ No funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ၉ 3□ DOA 28c. Injury at Work? 27. Menner of Death Certification: 28b. Time of 28d. Describe how injury occurred if or Attanding P setter death.

Diractor: After the in by the funera Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide To the Hospital or Atta Within 24 hours efter de To the Funaral Diracto completely filled in by ti Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifie

completed cause of death (Item 23a) (Type, Print)

Mi)

32. Fegistrar's Signature

ature & Sports

State Registrar 31. Date filed (Month, Day, Year) MAR 02

			For State Registrar		State of	of Maryla	and / Depa <i>Cei</i>	irtment of <i>tificate of</i>	Health and N Death		giene 00 L	08746	
			1. Decedent's Name (Firs	st, Middle, Last)				-	2. Date of Dea	ath Day Yea	3. Time of Death	
	Physicia /Medic		Dorcas		Elizal	beth		LOUIE		March	1 2004	4:20 A M	
	Examin		4a. Facility Name (If not i	institution, give	street and nu	ımber)		4b. City, Town,	or Location of Death		4c. County of De	eath	
			4935 Under			1 = 1		If I Indeed Man	Oakland r If Under 24 Hrs.	0.000		Garrett	
	Funeral		5. Social Security Number		x]M 21⊠F		rs. last birthday) Yrs.	Months Days		8. Date of Birt (Month, Da	y, Year)	Birthplace (State or Foreign Country)	
	Director		198-18-7196 Usual Residence of Dece			80				Oct. 21	1923	Maryland	
	and	1		. County		10c.	City, Town or Lo	cation				10d. Inside City Limits	
	Mary f sho	ŏ	MD	Garı	catt			0:	akland			1 ☐ Yes 2 ☒ No	
	28a	Director	10e. Street and Number	Gail	LELL			10f. Zip Code			10g. Citizen of What	Country?	
	30 o		4935 Under	wood Re	had				21550		ī	ISA	
	death ms 2	Funeral	11. Marital Status	.woou in		cedent Ever in	U.S. 13.	Was Decedent of	Hispanic Origin? (Sp ban, Mexican, Puerto	ecify Yes or No		merican Indian,	
٥	after or Ite		1 Never Married	2 Married		2]K] No		1 □ Yes 2⊠ N		, moun, oton,	Specify: V		
215-0036	hours after death with the Maryland lurel', or Items 23e or 28a-f show at Exacidizational be modified at	d by	3 ⊠ Widowed 4 □ I		Year or l	Dates:							
ດ້	72 h	Completed	15. l (Specify or	Decedent's Edi <i>nly high</i> es <i>t gr</i> ad	ucation de <i>completed</i>)	16a. Dece	lent's Usual Occi kind of work don	upation e <i>during most of worl</i> red)	ing	16b. Kind of Busine	ss/Industry	
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2	Hygie Hygie ther t		11th 17. Father's Name (First,	Middle, Last)			1 00	entral 5	upply Tech		Hospit Maiden Sumame)	Lal	
aŭ	intal }) Be	John			Gast	er		Elsie		- Bro	adwater	
Maryland	should be filed within 72 hours after death with the Marylan ad Mental Hygiene. marked other than "naturel", or flems 23e or 28a-f show imprice event, tre Medical Exterioral rush be indifficed at	ဥ	19a. Informant's Name/F	Relationship (T	ype, Print)	0200		ng Address (Stree		al Route Numbe	er, City or Town, State		
Z Z	lith ar 27 is rtreu		Elizabeth	V. Lou:	ie/dau:	ghter	4935	Underw	ood Road.	0akland	, Md. 2155	50	
ē,	s 1 ar f Hea item othe		20a. Method of Disposition	on		201	b Place of Disno			Date	20c. Location - City		
Ê	Page ent o nt: If ry or		1 ☑ Burial 2 ☐ Cre 1 ☑ Donation 5 ☐				-			/04	Oakland.	Marv1and	
altimore,	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked any injury or other treumetic as <u>once</u> .		'4 Donation 5 Other (Specify) Garrett Co. Mem. Gdns. 3/4/04 21. Signature of Funeral Service Licence 22. Name and Address of Facility Stewart Funeral Home										
ñ	Par E B) Sud	Day H-	Illa	N	3	2 S. Se	cond St.,	0akland	Md. 2155		
		23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between	
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	and P-trans	Examin	that initiated events resulting in death) Last		c	o (or as a cons	sequence of):	····					
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×	leath certifi attending I I for use as	2	IF FEMALE: 23b. Was decedent pred	gnant		utcome of pre		75			23d. Date of	delivery	
.O. Box	death certif e attending id for use a	cia	in the past 12 mor 1 ☐ Yes 2 ☑ No	ths?	4□Preg	birth 2 F gnant at time o]Ectopic pregnar] Other <i>(specify)</i>			Month	Day Year	
O.		Physician/M	9 🗆 Unknown		9□ Unk	nown							
ري م	es tha Igned be del	by P									obacco use contribute to the cause of death?		
ğ	w require been slo should b												
Division of Vital Records,	or Attending Physicien: The law requires that the star death. Director: After this certificate has been signed by the in by the funeral director, page 2 should be detach.	Completed	Chronic	Bronchi	tis					24a. Was autor	osv prior	autopsy findings available to completion of cause of	
Œ	nysicien: The law nis certificate has b I director, page 2 s	5	performed?									1? ′es 2□ No	
ita	cien: ertific actor,	Be	25. Was case referred to examiner?	medical	11			12	26. Place of Dea	th (Check only e	me)		
<u></u>	Physic this c	ုင္	1 ☐ Yes 2 ☑ No				2 ER/Outpatie	IL 3L DOM			dence 6 Other (S	pecify)	
N C	ding Ph h. After thi funeral	o		Pending	(Mo	e of Injury onth, Day Yea		W	ork? ☐ Yes 2 ☐ No	Zou. Describe	low injury occurred		
is:	death death ctor: / the	icat	2 ☐ Accident 3 ☐ Suicide 6	investigation Could not be		ce of Injury - A	At home, farm, st	eet, factory, office		28f. Location (Street and Number or	Rural Route Number,	
<u>></u>	l or Atten after deatl Director:	Certification:	4 Homicide	determined		ding, etc. (Sp		out, radioty, o		City or To	vn, State)		
	To the Hospitel or Attenwithin 24 hours after deatl To the Funerel Director: completely filled in by the		(Check only 2	Certifying Ph Medical Exam	iner: On the	basis of exam	knowledge, dear nination and/or in	h occurred at the vestigation, in m	time, date and place y opinion, death occu	, and due to the rred at the time,	cause(s) and manner date and place, and o	as stated. due to the cause(s)	
	thin 2 the the mplet	Medical	one) 29b. Signature and title	of certifier	and ma	inner stated.		29c. Lice	nse number		29d. Date signed (Mo	onth, Day, Year)	
	7. ¥. 7. 8			11	I.VA.	1			D1 E 2 2 2		3/5/0	1	
	1		30. Name and address	of person who	completed ca	use of death ((Item 23a) (Type	Print)	D15333		م امار	1	
	Ц		Thomas G.					urth St	. Oakland	. Md. 2	1550		
	St	ate	31. Date filed (Month, D	Day, Year)	32.	Registrar's S	ignature	4					
	Regist		MA	R - 4 2	2004	Par constant	K A	Goods					

State of Maryland / Department of Health and Mental Hygiene 10 08747 Certificate of Death 3. Time of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** March 2004 4:45 Lucille Levasseur /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Genesis ElderCare - Spa Creek Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6 Sex 5. Social Security Number **Funeral** 1 ☐ M 2 X F 1917 Maine 10, 86 005-01-5008 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, Ite Moulcal Exaciling must be reserved. 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 X No Maryland Anne Arundel Annapolis Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21403 P.O. Box 3322 Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MENo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married White 1 ☐ Yes 2 X No Specify: Baltimore, Maryland 21215-0036 Specify. ģ 3XWidowed 4 ☐ Divorced leted 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Compl Elementary/Secondary (0-12) College (1-4or 5+) Garment Manufacturing 10 Garment Worker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Marie Pelletier N.G. Brisson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Annapolis, Maryland 21403 Box 3322 Robert Levasseur / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2XX Cremation 3 Removal from State 3/8/2004 Galtimore, Maryland Baltimore Crematory * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 21. Signature of Funeral Service 1//line Annapolis, MD 21401 147 Duke of Gloucester St. Approximate Interval Between Onset and Death 23a. Part 1. Enter tife disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 6 MOWK LOWO **Physician** M /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician Physician/Medical the IF FEMALE: for use 23d. Date of delivery 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 4 Pregnant at time of death be detached 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 →NO 3 □ Probably 4 □Unknown Be Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed page 2 s has 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director Other: Hospital: 1 ☐ Inpatient 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Tyes 2 - No Certification: To this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After Hospital or Attending 5 Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No death. 2 Accident after death in by the f 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗍 Suicide 4 Homicide in 24 hours. the Funeral Director filled in 1 (Destifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature/and title of certifier 0 965 who completed cause of death (Item 23a) (Type, Print) 30. Name and 31. Date filed (Month Day, Year) Deteni 6 32. Redistrar's Signature

State

Registrar

8 2004

State of Maryland / Department of Health and Mental Hygiene 2004 08748 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death February 24, 2004 **Physician** 12:15 P M Virgil Lee Montgomery /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5332 Baltimore Ave. Chevy Chase Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Nov. 22, 1926 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**⊠**M 2□F 233-42-2052 77 West Virginia Director Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits utal Hygiene. ud other than "natural", or iteme 23e or 28e-f ahov event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Chevy Chase Director Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with t. Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or iteme 23a or 2 any hury or, other fraumatic event, the Medical Examiner must be not once. 20815 U.S.A. 5332 Baltimore Ave. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No World I Yes, Give Year or Dates:War II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) CIA Administrator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pearl Vernon Robert Garfield Montgomery 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5332 Baltimore Ave., Chevy Chase, MD Sophie Montgomery / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Assumption BVM Cem. Mar. 3, 2004 4 Donation 5 Other (Specify) Pulaski, WI 22. Name and Address of Facility Joseph Gawler's Sons, Inc. 21. Signature of Funeral Service Licenses MO1296 5130 Wisconsin Ave., NW, Washington, DC 20016 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic Prostate Cancer Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immodiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 🕅 No Month Year Day 4☐Pregnant at time of death 5 Other (specify) page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 1 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 PResidence 6 Other (Specify) 1 ☐ Yes 2 X No Medical Certification: To 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After t 1 XNatural 5 Pending Injury death. 1 ☐ Yes 2 ☐ No 4 hours after death. investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral I 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) February 25, 2004 MD D0033293 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #1300, Chevy Chase, MD Frederick P. Smith, M.D. 5454 Wisconsin Ave. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 01 MAR Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 08749 Certificate of Death 2. Dete of Deeth Month 1. Decedent's Name (First, Middle, Last) Пау Vear Physician February 28, 2004 6:20pm Rita Virginia Miller /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street end number) 4c. County of Death **Examiner** Golden Years Senior Care Center Montgomery Mt.Airv If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. lest birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** Devs Hours 1 M 25 F Months Director Oct. 12, 1912 Maryland 220-14-2400 Usuel Residence of Decedent permit. Pagas 1 end 2 should be filed within 72 hours after death with the Marylend Depertment of Health and Mental Hygiane. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f ahow any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. Stete 10b. County 10d. Inside City Limits 1 ☐ Yes 2 X No Director Maryland | Montgomery Potomac 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number 20854 12200 Espalier Place United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14 Race - American Indian. Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Nursing Registered Nurse 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ Vincent J. Miller Maud Neeler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12200 Espalier Place, Potomac, Maryland 20854 Paul G. Schuncke (Brother) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 2/29/04 Alexandria, Virginia 22. Name end Address of Facility DeVol Funeral Home 21. Signature of Funeral Service License 10 East Deer Park Drive Gaithersburg, MD 20877 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or fleart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) 2 WEEKS STROKE Examiner Due to (or es e consequence of): YEARS Examine HIPERTENSION sician and bunal-trensit or Attending Physician: The law requires that the death certificeta be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or es e consequence of): Part Ii. Other eignificant conditione contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown BMEN TIF þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an eutopsy performed? Be Completed 1 U Yes 2 2 No 1 □ Yes 2 □ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 COther (Specify) LIVIN Hospital: 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 1 Naturel 5 Pending n 24 hours after death.

• Funeral Director: After oletaly filled in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) and manner es stated. 29a. Certifier Medicai To the Hosp within 24 hor To the Fune completaly fi (Check only one) 2 Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier FEBRUARY 28, 2004 CENTER ST. #209 MT. AIRY, MD 21771 30. Neme end eddress of person who completed cause of death (Item 23e) (Type, Print) HARDING MO 602

Registrar **DHMH 16 Rev 6/95**

State

DAVID

31. Dete filed (Month, Day, Year)

MAR 0 1 2004

oaks

32. Registrer's Signature

State of Maryland / Department of Health and Mental Hygiene 2004 08750 For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 27, 2004 February 3:00 A Gorman D. McMullen /Medical 4c. County of Deeth 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Wilson Health Care Center Gaithersburg If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 € M 2 ☐ F 84 Yrs May 28, 466-10-3781 1919 Texas Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28a-1 show more interest of the Wadisal Examination to the resumatic event, the Wadisal Examination to the resulting and once. 1 ☐Yes 2√ No Maryland Montgomery Directo Gaithersburg 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 301 Russell Avenue, #444 20877 United States Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Bleck, White, etc. 1⊠Yes 2□No World
If Yes, Give War II
Year or Dates: War II 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify. Specify: White þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working Trade Elementary/Secondary (0-12) Coltege (1-4or 5+) Association Writer/Public Relations 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First, Middle, Last) Be Thomas Cary McMullen Ernest May Welch 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Timothy Cary McMullen/ Son 7525 Tarpley Drive, Derwood, Maryland 20855 20c. Location - City or Town, State Silver Spring, Date 20b. Place of Disposition (Name of 20a. Method of Disposition Cametery, crematory or other place)
Gate of Heaven
Cemetery March Silver Spring,
March Maryland

22. Name and Address of Facility Robert A. Pumphrey Funeral Home/
Bethesda-Chevy Chase Inc. 7557 Wisconsin Avenue,
Bethesda, Maryland 20814-3501 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee M00689 Rose Bethesda, Maryland Enter the Isease, or complications that caused the Teath. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart reliure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Immediate Cause (Final disease or condition brunde **Physician** /Medical resulting in death) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (of as a consequence of) Examiner death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) use as the burial-P.O. Box 68760, the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Be Completed by Bladder carcinorna, Parstate 90 1 Yes 2 No 3 Probably 4 Unknown carcinome. Hartiestensis. 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed page Stake Hypertenses Congetive heart failure 10 yes 1 Yes 2 No 2 1 No 26. lace 1 Death Check on one 25. Was case referred to medica examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Jursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Many of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation hours after death. 2 Accident the 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier At Robert Direchbackers 1)04/15 30. Name and address of person who completed cause of death (Item (LICOBERT BIRSCHBALLINUS) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 01 2004 Registrar

		1	For State Registrar AMEND#18perFH3	State of Ma 3/8/04,BMW,Md	i ryland / To	Depar Cert	rtment ificate	of Hea of De	alth and M eath	lental Hy	giene , Reg. No. ⁽	2004	08751	
	Physici	an	1. Decedent's Neme (First, Middle, Las Hazel Agnes	McConkey						2. Date of De Month Februa	Day	Year 2004	3. Time of Death 12:04 Au	
	/Medic Examin		4a. Facility Name (If not institution, give Montgomery Gene	street and number)	tal		4b. City, To		cation of Death		4c. County of Death Montgomery			
	Funeral Director		5. Social Security Number 6. S		(In yrs. last b	oirthday) Yrs.	If Under 1 Months I	Year If	Under 24 Hrs. Hours Min.	8. Dete of Bir (Month, De Jan. 2	th y, Year)	9. Birth	plece (Stete or Foreign intry) India	
٦	and w	-	Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Loca	ation						10d. Inside City Limits	
	Many a-f eho	tor	Maryland Montgo	mery	Sil	ver S	Spring	5					1 ☐ Yes 2 ☑ No	
	3a or 28	<u> </u>	10e. Street and Number 15423 Rowland	Lane			10f. Zip C	ode 2090	05		_	en of What Cou itain	intry?	
5-UU35 72 hours after deeth with the Maryland	I within 72 hours after deeth with the Marylan liene. Item. "naturel; or items 23a or 28a-f ehow the Musical Examinet mast be notified at	by Fur	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:			as Deceder Yes, specify		anic Origin? (Spo Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		I. Race - Amer Black, White Specify:		
9500-61212	c * 3	Completed	15. Decedent's Ec (Specify only highest gra Elamentary/Secondary (0-12)	de completed)	completed) (Gi			cedent's Usual Occupation ive kind of work done during most of working a. DO NOT use retired) Professional Artist			16b. Kind	of Business/I	ndustry	
₽ =	othe	Be	12 17. Father's Name (First, Middle, Last) Samuel Patterso				11016	18	Mother's Name	e (First, Middle,		'umame)		
	should nd Mei mark mark	유	19a. Informant's Name/Relationship (15	9b. Mailing	Address (Christi Number or Run	7.5		Town, State, Zi	p Code)	
, M	and 2 saith a n 27 io		Christine Stodda	rd (Daught					Ln., S					
Baitimore,	permit. Peges 1 and 2 should be Department of Health and Menta Importent: If them 27 is marked eny injury or other traumatic as once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		1	tery, crema	ition (Name atory or oth e Crei	er place)	Marc	h 2,		ation - City or T Ltsvill		
Rait	permit. Departimporti		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, Md. 20910											
	Pnysician /Medical		23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Finat disease or condition resulting in death)	plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Acute Pancreatitis Due to (or as a consequence of):									Approximate Interval Between Onset and Death 30 Hours	
	Examiner	ler	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury	b										
68760,	ficate be executed physicien and is the burial-transit	al Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c										
P.O. Box 68	death certi e attending rd for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ YNO 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Festal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)										ate of delivery Ionth Day Year	
	quires that the dei n signed by the a uld be detached f	Ď	Tallin. Office significant variations of the control of the contro											
Division of Vital Records,	Physician: The law requires that the this certificate has been signed by the rail director, page 2 should be detach	Completed								24a. Was auto perfo 1 Yes	psy prmed?	prior to death?	opsy findings available ompletion of cause of	
<u> </u>	sician s certif lirector	To Be	25. Was case referred to medical axaminer? 1 ☐ Yes 2 ☑ No	Hospital:	nt 2□FR/	Outpatient	3□ DOA	Othas	6. Place of Deat			□Other (Spec	ifv)	
ion of	fte ng		27. Manner of Death 1 Natural 5 Pending 2 Accident investigatio	28a. Date of Injur (Month, Day	28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work?					g Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred			.,,,	
Divis	al or Atters after des la Director od in by the	Certification;	3 Suicide 6 Could not be determined	286. Place of Inju	28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify)					281. Location (City or To		Number or Rui	ral Route Number,	
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical C		nysician: To the best of miner: On the basis of and manner sta	examination									
)		M	29b. Signature and title of certifier Dewett W	Corrige	mD			D4768				signed (Month ruary 2	, Dey, Year) 6, 2004	
	O		30. Name and address of person who					Cnr-	ina Rd	Olney	Мд	20832		
	St	ate	Bennett Morriso 31. Date filed (Month, Day, Year)	32. Registra	2901 U. ar's Signature		Sandy			orney	, riu.	20032		
	Regist	rar	MAR 0 5 20	104 Sene	/	N	July or							

State of Maryland / Department of Health and Mental Hygiene 004 08752 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2-26-04 5:14 P M Venetta Mandes /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) Examiner 01ney Montgomery Montgomery General Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 X F 90 2-22-1914 578-24-8430 Director Greece Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County or 28a-f show if Health and Mental Hygiene. Item 27 le marked other than "natural", or Items 23a or 28a-f ehov other traumatic event, the Musical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Montgomery Silver Spring 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 13809 Townline Rd. 20906 Completed by Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Stetus filed within 72 hours after of Hygiene. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Home 12 should be filed v th and Mental Hygie 7 Is marked other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elias Katranis Nicoletta Voudouris 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 end 2 Department of Health a Important: If Item 27 Is any injury or other tra Olybia Angelopoulos - Daughter 13112 Layhill Rd. Silver Spring, MD 20906 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State * 4 □ Donation 5 □ Other (Specify) Gate of Heaven 3-2-04 Silver Spring, MD 22. Name and Address of Facility Hines-Rinaldi F. H. 21. Signature of Funeral Service License luani 11800 New Hampshire Ave. Silver Spring, MD 20904 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death SYN Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of). **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner law requires that the death certificate be executed the attending physician and hed for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

RENAE FAILURE 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, à 2 100 3 Probably 4 Unknown icate has been sig 1, page 2 should b 1 Tyes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 Yes 2 certificate 2 2 No 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 27. Manner of Death 1-Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death.

Funeral Director: A investigation 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospitel 29a. Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai completely 든 **함** 29b. Signature a 29d. Date signed (Month, Day, Year) 29c. License number N O 30. Name and address of person who completed cause of death (Item 23a) Type, Print) OMT DR #211, SILVER SPRIME, MD20906 31. Date filed (Month, Day, Year)
MAR 0 1 32. Registrar's Signature State 2004 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene? 08753 Certificate of Death 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month **Physician** 29, 6:58 A M February 2004 Maydag William /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Anne Arundel Medical Center Annapolis 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 9. Birthplace (State or Foreign Country) New York 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** 1[XM 2□ F Yrs. Jan. 7, 1930 Director 056-22-6044 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location the Maryland 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23e or 28e-f show any injury or other traumatic event, Ite Medical Examinar must be notified at 28a-f show 1 Tyes 2XNo Gambrills Anne Arundel Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21054 2608 Chapel Lake Drive U.S.A. Be Completed by Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 TYes 2 No 1951 If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 ☐ No Specify: Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Coltege (1-4or 5+) Service Entrepreneur 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Gerks Marie Maydag William 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2608 Chapel Lake Drive, Gambrills, Maryland 21054 Marianne Maydag/ Wife 20b. Place of Disposition (Name of cometery, crematory or other place)
Maryland Veterans
Cemetery 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Crownsville, Maryland 3/4/2004 * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service Licensee 16000 Annapolis Road, Bowie, Maryland aller Smeth 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Intracerebral >20 **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical as IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy Year Month Day in the past 12 months?
1 Yes 2 No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ Diubetus mellitus 1 Yes 2 No 3 Probably 4 XUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Beriphoral vosculor 1 ☐ Yes 2 X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 Yes 2 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? To the Hospital or Attending Pt within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 4 | Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2-29-2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Peterson ATMIC 32. Bigistrar's Signature 31. Date filed (Month, Day, Year) State MAR 0 1 2004 Registrar

		For State Registrar	State of Ma	aryland / Dep <i>Ce</i>		ealth and I	Mental Hygid	3. No 2004	08754
Physicia /Medic Examin	al er	Rosemary A. Fecility Name (If not institution, Anne Arundel Medium)	H. Magne give street and number)		Annapol		1	Day Yeer Y 26 2004 4c. County of Deetl Anne Arun	ndel
Funeral Director		5. Social Security Number 579-52-2108 Usuel Residence of Decedent	6. Sex 7. Ag 1 ☐ M 2 🔀 F	e (In yrs. last birthday, 63 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 1)	Year) 9. Birth Co. 1940 Was	nplece (State or Foreign untry) shington, D.C.
ne Maryland 8a-f show	ector	MD 10b. County Anne	Arundel	10c. City, Town or L Arnold	3				10d. Inside City Limits 1 ☐ Yes 2∑ No
with the a or 2	Dire	10e. Street and Number 202 Nomini Dri	ve		10f. Zip Code 210	112	10	g. Citizen of What Co USA	untry?
if e, INGI yial IQ Z IZ I 3-0030 s 1 and 2 should be fited within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Maulical Examination into be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent Armed Forces?		Was Decedent of H If Yes, specify Cuba		pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, White	
thin 72 hours	Completed I	15. Decedent (Specify only highest Elementary/Secondary (0-12)	s Education	(Give	edent's Usual Occup e kind of work done o DO NOT use retired	during most of wor f)	king	6b. Kind of Business/	Industry
lbe filed winter Hygien ed other the	Be	17. Father's Name (First, Middle, L Joseph Holub	ast)		Homemake	18. Mother's Nan	ne (First, Middle, Mi		
should should mark marki	ဥ	19a. Informant's Name/Relationsh	ip (Type, Print)	19b. Mail	ing Address (Street			City or Town, State, Z	(ip Code)
C, Ma		John Barron Mag	gner/Husband	202	Nomini D	rive Ar	nold, MD	21012	
Page Page nent c ant: If		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 4 ☐ Donation 5 ☐ Other (Sp		Metro C	rematory or other place rematory	2	cuary 27, 2004	Oc. Location - City or Baltimor	
Dallill permit. Pa Departmer Important any injury		21. Signature of Funeral Service t	Toepsee	É	2. Name and Address Sarranco & 95 Gov. R	Sons, P	.A. Seve	rna Park E	Funeral Home
w requires that the death certificate be executed wrequires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	dlcai Examiner	23a. Part1. Inter the disease, or shoc, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Avte Due to (or as b. Due to (or/as c.	a consequence of): a consequence of): a consequence of):	NOTIC A	g, such as.cardiac	Disem	5 · L	Approximate Interval Between Onset and Death
.C. DOX 00/1	hysiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify) _	,		23d. Date of deli Month	ivery Day Year
w requires that the death been signed by the attershould be detached for L	by P	Part II. Other significant condition	ns contributing to death b	out not resulting in the	underlying cause giv	en in Part I.		acco use contribute to 2 □ No 3 □ Pre	the cause of death?
The lay ate has page 2	Completed						24a. Was an autopsy perform 1 Yes 2	ed? prior to death?	topsy findings available completion of cause of
Phy or this	atlon: To Be	25. Was case referred to medical examiner? 1 X Yes 2 No 27. Manner of Death 1 Natural 5 Pending investig		ury 28b. Time	of 28c. Injur Wor	er: 4 Nursing H	ith (Check only one lome 5 Residen 28d. Describe hov	nce 6 Other (Spec	city)
DIVISION tal or Attanding s after death. al Director: After ed in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	ned 286. Place of in	jury - At home, farm, s lc. <i>(Specify)</i>	treet, factory, office		28f. Location (Stre City or Town,	eet and Number or Ru State)	ral Route Number,
he Hospi in 24 hour ihe Funer pletely fill	edical	29a. Certifier 1 Certifyin (Check only one)	g Physician: To the best Examiner: On the basis of and manner st	of examination and/or i	nvestigation, in my o	pinion, death occu	irred at the time, dat	te and place, and due	to the cause(s)
To 1 with To 1	Σ	29b. Signature and title of certifier	-P- C.	Deput	29c. Licens	e number 060	54	d. Date signed (Month 2/27, 2/035	n. Day, Year)
		30. Name and address of person	who completed stuse of a De Son	death (Item 23a) (Type	695	- Ame	rick o	21035	
Sta Regist		31. Date filed (Month, Day, Year)		rar's Signature	Charles .				

State of Maryland / Department of Health and Mental Hygiene? 08755 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** Year February 25 2004 6:15 p /Medical James Gilbert McNamara. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 404 Secret Bend Apt. Glen Burnie Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1**X** M 2 □ F 220-60-7943 Director 52 Nov. 18, 1951 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at MD Anne Arundel Glen Burnie 1 ☐ Yes 2 ☑ No Director 10e. Street and Number 10f Zin Code 10g, Citizen of What Country? 404 Secret Bend Apt. D 21061 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married ŏ Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ Specify: White 3 ☐ Widowed 4 ☑ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry pemit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene Important: If item 27 is marked other than any injury or othar traumatic avent Elementary/Secondary (0-12) College (1-4or 5+) Sales Fire Protection 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James Gilbert McNamara, Sr. Helen Jeanette Clary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kelly A. McNamara/Daughter 108 4th Avenue S.E. Glen Burnie, MD 21061 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition March 1. 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Glen Haven Cemetery 5 Other (Specify) 4 Donation Glen Burnie, MD 21. Signature of Fineral Service I 22. Name and Address of Facility
Barranco & Sons, P.A.
495 Gov. Ritchie Hwy. Severna Park Funeral H Severna Park, MD 21146 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner burial-transit be executed and Due to (or as a consequence of): Box 68760, the attending physician Physician/Medical as the IF FEMALE esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy detached for in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No O 9 Unknown ģ prificant conditions contributing to death but not resulting in the underlying cause given in Part I. signed 23e. Did tobacco use contribute to the cause of death? Records, pe 3 Probably 4 Unknown 1 🗌 Yes Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate 1□ Yes 2□Mo of Vital in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other 4 Nursing Home 5 Mesidence 6 Other (Specify) 20 No ပ 1 Tyes 1 Inpatient 2 ER/Outpatient 3□ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: Alter Division 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifig 29c. License numbe 29d. Date signed (Month, Dey, Year) 30. Name and agreess of person who completed cause of death (Item 23a) (Type, Print) DR. TKCK Lichtenstein 205 31. Date filed (Month, Day, Year) 32. Restrar's Signature State MAR 0 2 2004 Registrar

		1	For State Registrar	State of M	aryland /		rtment of He tificate of D		R	g. No.		08756
	Dhysinis		Decedent's Name (First, Middle						2. Date of Dear	Day	Year	3. Time of Death
Е	Physicia /Medic	al L	Edward Berna				4b. City, Town, or L	ocation of Death	March		72004 ounty of Death	10.)0 7
	Examin		Ia. Fecility Name (If not institution	rundel	1+05p	57~1	If Under 1 Year	Il Under 24 Hrs.	8. Date of Birth	AY	nne x	9 vnd→) lece (Stete or Foreign
И	Funeral Director		5. Social Security Number 057–07–7354	6. Sex 7. As 1⊠ M 2□ F	ge (In yrs. Mest i 86	Yrs.	Months Days	Hours Min.		, Year)	Cour	NY
S			Usual Residence of Decedent									0d. Inside City Limits
	Marylan		MD 10b. County Anne	Arundel	10c. City, To	own or Lo		rna Park				1 □ Yes 2 🔀 No
	with the 3a or 28a I be not	i Direc	10e. Street and Number 6 Leeward Court				10f. Zip Code	1146		0g. Citize	n of What Cour USA	ntry?
36	be lied within 72 hours after death with the Maryland ital Hygiene. d other then "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Marr 3 ☑ Widowed 4 ☐ Divorced	If Yes, Give	? No WWII	- '	Was Decedent of His I Yes, specify Cuban 1 ☐ Yes 2☑ No	panic Origin? (S , Mexican, Puerl Specify:	pecify Yes or No- o Rican, etc.)		. Race - Americ Black, White, pecify:	
21215-0036	vithin 72 hou ne. hen "neture ie Medical E	Completed	15. Deceden (Specify only highe Elementary/Secondary (0-12)	t's Education st grade completed) College (1-4or 2		(Give	dent's Usual Occupa kind of work done di DO NOT use retired) Fireman	uring most of wo	rking	New	of Business/In York C e Depar	ity
Maryland 21	be lited tal Hygi d other event, I	Be	17. Father's Name (First, Middle, Edward McElroy	Last)		_			me (First, Middle, Vard			
aryl	should ind Men in marke	2	19a. Informant's Name/Relations	ship (Type, Print)	1	9b. Maili	ng Address (Street a	nd Number or Ri	ural Route Numbe	r, City or T	own, State, Zip	Code)
	of Health of Health item 27	İ	Eileen Stroud, 20a. Method of Disposition 1 XBurial 2 Cremation	3 □Removal from Stat	e ceme	of Dispositery, crea	sition (Name of matory or other place Heaven Cer	Mar	verna Par 10 12, 2004	20c. Loca	D 2114 ation - City or To nalla, I	own, State
Baltimore,	permit. Page Department Important: If any injury or		*4 □ Donation 5 □ Other (S 21. Signature of Funeral Service		Gate	22	0. Manage and Address	s of Facility	P.A. Seve	erna i	Park Fu	neral Home
	Physician /Medical Examiner	iner	23a. Part1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	a	Pr	ice of):	The mode of dying or the mode	19	e or respiratory ar	rest,		Approximate Interval Between Onset and Death
68760,	cate be executed physician and the burial-transit	dicai Examiner	that initiated events resulting in death) Last	cDue to (or a	as a consequen	ice of):						
Вох	requires that the death certificate teen signed by the attending physic nould be detached for use as the t	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal de at time ol deat	ath 3	□Ectopic pregnancy □ Other (specify)			23	d. Date of deliving Month	rery Day Year
ds, P.O.	uires that t signed by d be detac	b	Part II. Other significant condit	ions contributing to death	n but not resulti	ng in the I	underlying cause give	en in Part I.	23e. Did t	-	ſ	the cause of death?
Records,	e law has b	Completed							24a. Was autoj perfo 1 🗆 Yes		24b. Were aut prior to c death? 1 \(\text{Yes}	opsy findings available ompletion of cause of
Vital	ician: Th certificate rector, pag	Be	25. Was case referred to medic examiner?	Hospital			Oth		eath (Check only o			
o	g Phys er this eral di	lon: To	1 Yes 2 No 27. Manner of Death 1 Hatural 5 Pend	28a. Date of I (Month,		VOutpatie 8b. Time Injury	ol 28c. Injun Worl	4 Nursing	Home 5 Resi			ity)
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	3 Suicide 6 Could	280. Place of	Injury - At hom etc. (Specify)	e, farm, s	treet, lactory, office		28l. Location (City or To		Number or Ru	ral Route Number,
	a Hospita 24 hours • Funeral etely filled	dical	29a. Certifier (Check only ane)	ing Physician: To the be at Examiner: On the basi and manner	s of examinatio	edge, dea n and/or i	ath occurred at the tin investigation, in my o	ne, date and plac pinion, death occ	ce, and due to the curred at the time,	cause(s) a date and p	and manner as place, and due	stated. to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certif	P.	mD		29c. Licens D 1+8				signed (Month	11-
			30. Name and address of person	m who completed cause of	death (Item 2	23а), (Туре	OS Stal	Dro	, 5/2	n B	~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~	4, mi
	S Regis	tate trar	31. Date liled (Month, Day Yea	0 8 2004 32 Reg	Irar's Signatu	re	South		,			

		1 - For Stete Registrar	State of Ma	aryland		rtment			nd Me		iene _{9. No.} 2	004	087	157
Dhusia		1. Decedent's Name (First, Middle, Last)								. Date of Deat Month	Day	Year	3. Time of D	
Physic /Med		KATHE MARIA MCKI				4h Cihi	Faura 01	Location of D		ARCH	2	2004 inty of Death	1700	М
Exami	ner	4a. Facility Name (If not institution, give s 24810 DEEP WATER		F				CHAEL:				CALBOT		
Funeral		5. Social Security Number 6. Sex	7. Age		st birthday)	If Under Months		If Under 24	Hrc o	Date of Birth	Year)	Cour	lace (State or	Foreign
Director		579-10-3240	M 2 🛣 F	85	Yrs.	Worth	Days	110010	1	(Month, Day, AUG 4 1	918	GERM	IÁNY	
and w.		Usual Residence of Decedent 10a. State 10b. County		10c. City,	, Town or Lo	cation						1	0d. Inside City	Limits
ith the Marylar or 28a-1 show	tor	MD TAL	вот		ST. M	IICHAE	LS						1 🗆 Yes	XXNo
th the or 288	Director	10e. Street and Number				10f. Zip	Code			1	0g. Citizen	of What Coul	ntry?	
ath wi	rai	24810 DEEP WATER					1663		2/6200	fu Vac or No	14.1	USA. Race - Americ	an Indian	
after death w	Funeral	11. Marital Status 1 Never Married 2 Married	12. Was Decedent I Armed Forces? 1 ☐ Yes 2 🛣	ever in U.S No				n, Mexican, P	Puerto Ri	fy Yes or No- can, etc.)		Black, White,	etc.	
urs at	b	3 Widowed 4 Divorced	If Yes, Give Year or Dates:			î □ Yes :	2X No	Specify:			Spe	ecify: Wh	IITE	
I. A. I.3-UUSO within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-1 show to Madical Examinar must be notified at	Completed	15. Decedent's Educ (Specify only highest grade	cation completed)		16a. Deced	dent's Usua kind of woi DO NOT us	k done d	uring most of	of working	7	16b. Kind o	f Business/In	dustry	
within and than than	mp	Elementary/Secondary (0-12)	College (1-4or 5	5+)		ARTNI		,		F	ATENT	ATTO	NEY	
If yearloo Z 1 Z should be filed within to Mental Hygiene. marked other than matic event, tre M	a	17. Father's Name (First, Middle, Last)						18. Mother's	s Name (First, Middle, M				
ary tarious should be fill and Mental Hy marked oth umatic even	To B	PAUL SPEICHER								UNKNOWN				
2 6 5 C		19a. Informant's Name/Relationship (Type				-				Route Number PREST				
re, no is 1 and of Health itam 27 other tr		MERLIN M. EVANS/SC)N	20b. Pl	ace of Dispo	sition (Nan	ne of	Ţ	Dat	-		on - City or To		
Pages nent of I		1X Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State		T.TNCC			⁹⁾ ₹RY 3-	- 9-20	004 F	BRENTV	100D. N	IARYLAN	D
보 실원원급	á	21. Signature of Funeral Service License	90	,	20	Name an	d Addres	s of Facility		& NEWNA				
Depa impo			MERCI		20	00 S.	HARI	RISON :	ST E	ASTON,	MD 21	601		
		23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused ne caus , on each li	the death	, ,	1	an						Approximate Interval Betw Onset and D	reen
Physiciar /Medica		Immediate Cause (Final disease or condition resulting in death)	Cagr	cint	E5/17	nal 1	ten	works	ige					
Examine	_		Reter	12 CC	ente	· Ca	1010	vasulo,	K 1	015005	Q			
7 X 3 EVA	ner =	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Tue (or as	a consequ										
6U, be executed ician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequ	ience ol):							-		
	calE		4											
ob/			$S_{\rm m} = m_{\rm ext}$		10.									
. BOX bB death certificat e attending phy d for use as th	Physician/Med	236. Was decedent pregnant	3c. If yes, outcome 1 ☐ Live birth		death 3	⊒Ectopic pi					23d.	Date of deliv Month	*	ear
. 0 0 0	sici	in the past 12 months? 1 ☐ Yes 2 ☐ ₩0	4□Pregnant a 9□Unknown	t time of de	eath 5	Other (sp	ectfy)						,	
- E B B		Part II. Other significant conditions con	ntributing to death b	out not resu	alting in the u	inderlying o	ause give	en in Part I.		23e. Did to	bacco use	contribute to t	he cause of de	ath?
Vital Records, sician: The law requires! certificate has been signe irector, page 2 should be	ed by									1 □ Y	es 2□N	o 3 🗆 Pro	oably 4 🔟	aknown
	Completed									24a. Was a	in 2	prior to co	opsy findings a impletion of ca	vailable use of
I Hec The law ate has b	Com									perfori 1 Yes	med? 2 □ No.	death?	2 N e	
Of Vital HeC Physician: The law r this certificate has t ral director, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:		- F. C		Oth			(Check only or		O.b /C	6.1	
hy hy	1: 70	1 ses 2 No 27. Manner of Death	28a. Date of Inju		28b. Time of		28c. Injun Wor	4 IAUIS		e 5 🔀 Reside 3d. Describe h			y)	
VISION Attending r death. ector: After by the fune	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Da	ly 19ai)	Injury	М		Yes 2 □ No	0					
Division C al or Atlending P after death. Director: After i	Certification:	3 Suicide 6 Could not be determined	28e. Place of In building, e	jury - At ho tc. (Specify	ome, larm, st	reet, factor	y, office		28	Bf. Location (S. City or Town		umber or Aur	al Route Numb	er,
To the Hospital or within 24 hours after To the Funeral Director completely filled in In		29a. Certifier 1 ☐ Certifying Phy	sician: To the heet	ol my kno	wiedge, deat	th occurred	at the tin	ne, date and	place ar	nd due to the c	ause(s) and	i manner as	stated.	
e Hospita 24 hours e Funeral	edical	(Check only one)	ner: On the basis of and manner st	ol examinat	tion and/or in	ivestigation	, in my o	pinion, death	occurred	d at the time, d	late and pla	ce, and due t	o the cause(s)	
To the within 2 To the complet	Me	29b. Signature and title of certifier	//					e number	4.5	2		gned (Month,	Dey, Year)	
		1/21/1/6	ph MD	~			DO C	1442	8 2		3/9	104		
		30. Name and address of person who d					יזינאדר	מס מק	ΥΕΛ υι	ר מוא מ	1654			
N. 5	State	CLAUDE KOPROWSKI 31. Date liled (Month, Day, Year)		rar's Signa	MUTELL ture		ハエバエ	KD. 02	VLOKI	עניו , ע	. + 0.24			
1	strar	31. Date liled (Month, Day, Year)	32 Regist	. 4		0.102								

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	y * 5		Decedent's Name (First, Middle, Last)							2. Date of De	aath	V	3. Time of Death
4	Physici /Medic		Betty J. Mc	:Kenzie								Month FEBRU	ARY 2	28, 2004	0210 A ^M
	Examir		4a. Facility Name (If n	ot institution, give	street and numb	er)		4b. City,	Town, or	Location of	f Death		4c.	County of Death	
****		200	SACRED HE				 	CUMB			24 14-0			ALLEGANY	
	Funeral Director		5. Social Security Num 219-14-5683	10	- And -	Age (In yrs.	last birthday) Yrs.	If Under Months	Days	Hours	Min.	B. Date of Bi (Month, Da 08-Jul-	rth ay, Year) -1923	Cou	place (State or Foreign ntry) Iland
	and **		Usual Residence of D 10a. State 1	ob. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
	f sho	ō	Maryland	Allega	ny	Frost	burg								1 A Yes 2 □ No
	28a-	rect	10e. Street and Numb					10f. Zip	Code				10g. Citiz	zen of What Cou	ntry?
	3a ou	<u> </u>		o oovann				2153	32-				U.S.A.		
36	be filed within 72 hours after death with the Maryland hal Hygiene. d other than "natural", or Items 23a or 28a-1 show event, the Medical Examiner must be putilised at	by Funeral Director	11. Marital Status 1 Never Married 3 Widowed 4	_	12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	No No		Was Deced If Yes, spec	rify Cubar	spanic Orig n, Mexican, Specify:	jin? (Spec , Puerto R	rfy Yes or No ican, etc.)		14. Race - Americ Black, White, Specify: White	etc.
9	hour	edt		5. Decedent's Edu			16a. Dece	dent's Usua	d Occupa	tion				nd of Business/In	
21215-0036	- 74	Completed		only highest grad	College (1-4)	or 5+)	(Give	kind of wor DO NOT us	k done di	uring most	of workin	g	mote		
d 2	filed Hygi ther ont,		17. Father's Name (Fi	rst, Middle, Last)			<u> </u>			18. Mother	r's Name	(First, Middle	, Maiden	Sumame)	
an	should be filed within and Mental Hygiene. marked other than matic event, the M	To Be	Edward M.	Payne						Lucy	B. Wad	de			
Maryland	2 8 8 3	-	19a. Informant's Nam		/pe, Print)		19b. Mailir 3642 B	ng Address rookwoo	(Street a	(0)		Route Numb		Town, State, Zip	20695-
	is 1 and 2 of Health Item 27 other tra		20a. Method of Dispos	sition		20b. P	lace of Dispo	sition (Nan	ne of		Da	-		cation - City or To	
Baltimore,	Pa men ent: ury		° 4 □ Donation 5				emetery, crer stburg Me	emorial i	Park	1		or-2004	Frostb	urg M	aryland
Bai	permit. Depart Import any inj		21. Signature of Fune	ral Service Licens	Duris	1		name an		5		st Ave.,	Frostb	urg, MD 2	1532
,00	Medical Examiner bh/sician and st the burial-transit	Examiner	flany, leading to imm cause. Enter Underly Cause (Disease or inj that initiated events resulting in death) Las		b Due to (or	as a conseq as a conseq as a conseq	uence of):								
8760,	cate b	dica			d.										
.O. Box 6	ne death certif the attending hed for use a	Physician/Medical	IF FEMALE: 23b. Was decedent p in the past 12 m 1 ☐ Yes 2 2 10 9 ☐ Unknown	onths?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnan 9 ☐ Unknown	2 ☐ Feta t at time of d	Ideath 3	Ectopic pre					2	3d. Date of delive Month	ery Day Year
σ.	equires that the second of the	by	Part II. Other signification of	ant conditions co	ntributing to deat	h but not res	ulting in the u	nderlying ca	ause give	n in Part I.			tobacco us		ne cause of death?
Records,	The law requi	Completed	Lynflower	and f	Peiphers	Vac	h	Direc	ne			24a. Was auto perfo 1 2 Yes		prior to co death?	psy findings available mpletion of cause of
Vital		Be C	25. Was case referred	d to medical						26. Place	of Death	Check only			
of V	Physician; this certific ral director,	10	examiner? 1 TyYes 2 ☐ No		Hospital:	atient 2	ER/Outpatier	nt 3□ DO	A Other	r: 4 🗆 Nur	sing Hom	e 5⊡ Resi	dence 6	□Other (Specif	y)
0	ding Ph h. After th funeral		27. Manner of Death 1. Natural	5 Pending	28a. Date of I (Month,	njury Day Year)	28b. Time of Injury	2	8c. Injury Work	at ?	28	d. Describe	how injury	occurred	
<u>s</u> i	Attending or death. ector: After by the funer	catl	2 Accident	investigation				М	1 🗆 Y	es 2□N	10				
Division	s after d	Certification:	3 ☐ Suicide 4 ☐ Homicide	determined	28e. Place of building.	Injury - At ho , etc. <i>(Specif</i>)	ome, farm, str y)	eet, factory	, office		28	If. Location (City or To		l Number or Rura	li Route Number,
	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical	29a. Certifier 1 (Check only one)	☐ Certifying Phy ☐ Madical Exam	sician: To the be ner: On the basi and manner	s of examina	wledge, deatl tion and/or in	n occurred a vestigation,	at the time in my opi	e, date and inion, deat	place, ar h occurre	nd due to the d at the time,	cause(s) a date and	and manner as s place, and due to	tated. the cause(s)
	To the within To the comp	Me	29b. Signature and tit	le of certifier				29c	. License	number			29d. Date	signed (Month,	Day, Year)
	5		The	ohn l	1 Ki	Kn	200		001	Æ			FEBR	UARY 29	2004
			30. Name and addres	s of person who c	ompleted cause	of eath (Iten	n 23a) (Type,	Print)							
	The		THEVDO	RE M.	Kung	11	1 Penn	Stre	et,	Balti	more	Mary	land	21201	
夢	Sta Regista		31. Date filed (Month)	0 2 2004	32. Reg	istrar's Signa	lture	1				_			

Registrar DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 08760 Certificate of Death Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day **Physician** 27 2004 6:00 A M FEB. ROLAND ELWOOD MILLER /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Deeth 4b. City. Town, or Location of Death **Examiner** QUEEN ANNE'S CORSICA HILLS NURSING HOME CENTREVILLE If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 1 M M 2 □ F 7. Age (In yrs. last birthday) Date of Birth (Month, Day. **Funeral** oct. 18, 1910 Months Days Hours MARYLAND Yrs. 93 Director 213-01-5691 Usuel Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a, State ral', or Items 23a or 28a-f show Exercites must be notified at 1 Yes 2 □ No MD QUEEN ANNE'S CENTREVILLE Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21617 USA 205 ARMSTRONG Completed by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married ☐Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: Specify: WHITE 3 Widowed 4 □ Divorced "natural" permit. Pages 1 and 2 should be filed within 72 hc Depertment of Health and Mental Hygiene. important: if Item 27 is marked other than "natur any injury or other traumatic avant, the Medical once. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) BAY BRIDGE POLICE POLICE OFFICER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be "IINKNOWN" AMANDA MILLER 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 24150 CARRLYN DRIVE, RIDGELY, MD 21660 LARRY A. SEWARD/GRANDSON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State CHESTERFIELD CEMETERY MAR.1,2004 CENTREVILLE, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, 408 S. LIBERTY ST., CENTREVILLE, MD 21617 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Zheimer 5 **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Dualto (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760 by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day detached for 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No Division of Vital Records, P.O. 9□ Unknown 9 Unknown been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 🗌 No 1 Yes 2/1NO 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: Medical Certification; To 1 Tes 2 No 2 ER/Outpatient 3 DOA 4 rsing Home 5 Residence 6 Other (Specify) 27. Mann-J Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation the 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 4 Homicide per 29a. Certifier 🗺 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 555 CYNWOOD DRIVE, EASTON, MD 21601 DENTON, M.D., JEFFREY J. 32. Register's Signature 31. Date filed (Month, Day, Year) State 04 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiena, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month FEBRUARY 25, SIDNEY NATHANSON 11:10 A^M 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1111 UNIVERSITY BLVD., WEST #1115 SILVER SPRING MONTGOMERY 5. Social Security Number If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year NOV 30 2 19 **Funeral** Birthplace (State or Foreign Country) 1∏M 2□F Months Director 91 577--05--8460 NEW YORK 1912 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location er than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits Director 1 ☐ Yes 2 No MARYLAND MONTGOMERY SILVER SPRING 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1111 UNIVERSITY BLVD, WEST #1115 20902 Funeral UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ZNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural, or ite any injury or other treumatic event, the Mudical Examples once. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ If Yes, Give Year or Dates: 1 ☐ Yes 2 X No Specify: Specify: 3 X Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PROPRIETOR LIQUOR STORE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ို SOLOMON NATHANSON SOPHIE REICHICK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RAE TOBY NEWMAN-KULLBACK, DAUGHTER 7420 WESTLAKE TERRACE, #203 BETHESDA, MD 20817 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete ■ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) B'NAI ISRAEL CEMETERY 2/27/04 OXON HILL, MARYLAND 21. Signature of Funeral Service Licenses 22. Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 ROCKVILLE PIKE, ROCKVILLE, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician CARDIAC ARRYTHMIA /Medical Due to (or as a consequence of): Examiner CORONARY ARTERY DISEASE Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Dua tu (or as a curisequanea of) The law requires that the death certificate be executed HYPERTENSION for use as the burial-tran Due to (or as a consequence of): Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 1 Yes 2 No should be detached 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by DIABETES 1 ☐ Yes 2 ☐ Xio 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performs 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No page 2 2 **X**10 1 ☐ Yes To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 AResidence 6 Other (Specify) 1 ☐ Yes 2 🔀 No Certification; To 2 ER/Outpatient 3 DOA s after death.
I Director: After this
id in by the funeral d 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Division 5 Pending investigation Injury 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide pen within 24 hours To the Funeral 1 Certify g Physicia : To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Media | Examiner: on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D59284 FEBRUARY 26, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHAHID SHAMIM, M.D., 1299 LAMBERTON DRIVE, SILVER SPRING, MARYLAND 31. Date filed (Month, Day, Year) State 32. Registrar's Signature

Registrar

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Vledic	an	1. Decedent's Name (First, Middle, Las	,			2. Date of Death Month	Day Yeer	3. Time of Death
amin		Teofilo Ochoa 4a. Facility Name (If not institution, give		4h City	Town, or Location of De	February	20, 2004 4c. County of Death	0320 A
amm	ei 4	1641 East Baltimo				,	va. odany or boat	
eral		5. Social Security Number 6. Se	7. Age (In yrs. last I	pirthday) If Under		frs. 8. Date of Birth (Month, Day,	9. Birth	plece (State or Foreig
ctor		None	X 2□ F 35	Yrs.	Days Flours IV	Dec. 30,		Salvador
1		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	wn or Location				10d. Inside City Limits
Exacting material be multipled at	lor							1 □ Yes 2√2 No
and a	Director	Maryland 10e. Street and Number	Dā.	ltimore 10f. Zip	Code	100	g. Citizen of Whal Co	untry?
1 50		1641 East Balt	imore Street	2	1231		El Salvado	
	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?		lent of Hispanic Origin? offy Cuban, Mexican, Pu		14. Race - Amer	ican Indian,
		1 ☑ Never Married 2 ☐ Married	1 ☐ Yes 2 ☑ No If Yes, Give		2□ No Specify:	Salvadora	Black, White	
	d by	3 Widowed 4 Divorced	Year or Dates:					
	Completed	15. Decedent's Edi (Specify only highest grad	de completed)	ia. Decedent's Usua (Give kind of wor life. DO NOT us	k done during most of	working 16	6b. Kind of Business/I	ndustry
	mc	Elementary/Secondary (0-12)	College (1-4or 5+)		ion Worker		Constant	
	0	17. Father's Name (First, Middle, Last)		Constituct		lame (First, Middle, Ma	Construc	tion
	To B	Natebida Ochoa			м	aria o i		
	-	19a. Informant's Name/Relationship (T	ype, Print) 19	b. Mailing Address		aria Ochoa Rural Route Number, (City or Town, State, Zi	ip Code)
		Dolores Delcid /	Brother 4	323 Masha	in Road. S	ilver Sprin	e MD 200	906
	-	20a. Method of Disposition	20b. Place	of Disposition (Named Property) of other	ne of	Date 20	Oc. Location - City or T	
)		1 ☐ Burial 2 ☐ Cremation 3 ② 1 ☐ Donation 5 ☐ Other (Specify)	San I	uis DeLa	rena	rch 8, 2004 S	an Mi uel,	F1 Salwad
Dines: O		21. Signature of Funeral-Service Ligens	600	me te ry	d Address of Facility			HI DGIVAU
ona		23a. Part1. Enter the disc se, or comm	Scerlo	500 Uni	iversity R1	s Funeral 1 vd. W., Si	Home Inc.	MD 300
burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence. Due to (or as a consequence.					
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*	Physici	40	1. Decedent's Name (First, Middle, Last)) Mon	of Death] th	Februar 29, 200	y 3. Tir	me of Death
1	/Medic	al	John Thomas Oa 4a. Facility Name (If not institution, give s			4b. City	, Town, or	Location of [aary	4c. County of I		TOA.
	Examin	er	Forest Glen and Re			Sil	ver S	pring			Montgo	mery	
	Funeral		5. Social Security Number 6. Sex	M 2 F		If Unde	r 1 Year Days	If Under 24	Min. (Mor	of Birth oth, Day, Ye	ear)	Country)	itate or Foreign
(- .s.	Director		216-50-8702 Usual Residence of Decedent	54	Yrs.				Sept	. 8,	1949 W	ashing	ton, DC
1	yland 10W		10a. State 10b. County	10c. City	, Town or Lo	ocation							ide City Limits
	Se-fs	ctor	Maryland Montgom	ery S:	ilver]Yes 2∏No
1	De or	Funeral Directo	10e. Street and Number			10f. Z	ip Code			10g	. Citizen of Wha	•	
÷	18 23g	erai	9709 Nassau Lane	12. Was Decedent Ever in U.	S. 13.	Was Deci	209 edent of Hi		n? (Specify Yes	s or No-		American Indi	an,
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Maryland 21215-0036	ural',	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates: 1968-	70					40			
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פ	be filed witter Hygien of other the	Be C	17. Father's Name (First, Middle, Last)					18. Mother's	Name (First,	Middle, Ma	iden Sumame)		
<u>ya</u>	should to and Ment marked umatic	2	John L. Oakley		405 14530		· · · (Ct1		gina A.		ity or Town, Sta	to Tin Codel	
Mar	o 2 sh th and 7 is m traum		19a. Informant's Name/Relationship (Ty			•					ing, MD		
45	s 1 and 2 should if Health and Men ifem 27 is marke other traumatic		Nancy J. Oakley, 20a. Method of Disposition	W11e 20b. P	lace of Dispo emetery, cre	osition (Na	ame of		Date		c. Location - Cit		ate
E .	Page = ≥O		1 ☑ Burial 2 ☐ Cremation 3 ☐ P '4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	t Linc			p. I.C.	rch 6, 2004	Br	entwood	l, Mary	land
Baltimore,	permit. Pages 1 Department of H Importent: If itel any injury or ott		21. Signature of Funeral Service License	ee 2 1	2: F1	2. Name a	and Addres	ss of Facility	ns Fune	ral H	lome Inc	iones es	
	Physician /Medical Examiner		23a. Part1. Enter he disease, or compleshock, or heart failure. List only or Immediate Cause Facilities or condition resulting in death)	ications that caused the death ne cause on each line. Head am Due to (or as a consequence)	d Ned	ter the mo	ode of dyin	g, such as ca	Lvd. W.	• S11 atory arrest	ver Spr	Appro	D 20901 eximate at Between and Death
	icate be executed physician and sthe burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	Due to (or as a consequence of the consequence of t									
.O. Box 68	The law requires that the death certificat ate has been signed by the attending phypage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of do 9 ☐ Unknown	death 3	⊒Ectopic ⊒ Other (pregnancy specify)	,			23d. Date of Month		Year
ď	s that t ned by a detai	by Ph	Part II. Other significant conditions co	ntributing to death but not resi	ulting in the u	underlying	cause giv	en in Part I.	23	e. Did toba	cco use contribu	ute to the caus	se of death?
rds	w requires t been signe should be								_	1 🗆 Yes	2 ANO 3	Probably	4 Unknown
		Completed								a. Was an autopsy performe Yes 2	d? prid	re autopsy find or to completion wh? Yes 2 \(\) N	
/ita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			Oth		of Death (Chec				
ot	ding Phys h. After this funeral dii	ation: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	1 ☐ Inpatient 2☐ 28a. Date of Injury (Month, Day Yeer) 2-29-6 ←	28b. Time of Injury		28c. Injun Wor	4 🗆 14013	28d. De	scribe how	injury occurred a metor	gule st	
		Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	v)	treet, facto	ory, office		28f. Loc	ation (Street) or Town,	et and Number State)	or Rural Route	n Rd and
	Hospitel or 24 hours affe Funerel Dir tely filled in	edical		sician: To the best of my kno iner: On the basis of examina and manner stated.									ause(s)
٠,	To the to the to the to the to complete	Med	29b. Signature and title of certifier			2	9c. Licens O.C.I				l. Date signed ('ebuary		
1			30. Name and address of person who c	ompleted cause of death (Item	n 23a) (Type	, Print)]	L11 P	enn St	reet, E	Baltim	ore, Ma	ryland	21201
Ī	St Regist	ate rar	31. Date filed (MAR 03 200	32. Pegistrar's Signa	Sture	1	ocks	1					

			1 - For State Registrar	State of Mary		artment of rtificate or		Mental Hy	/giene Reg. No.2	004	08765
	Physic /Medi Exami	cal	1. Decedent's Name (First, Middle, La: DAN LE 4a. Facility Name (If not institution, give	OTE	37	4b. City, Town,	or Location of Dea	2. Date of D Month FEB	Day 29	Year Zoo Y	3. Time of Death
	Funeral Director		320-20-0120	9x 7. Age (In 2	yrs. last birthday) Yrs.	Beti If Under 1 Yea Months Day			irth ay, Year)	ontgom 9. Birthp Cour The	nery place (State or Foreign ntry) Netherland
	e Maryland Sa-f show diffed at	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Montgot		City, Town or Lo	ersburg					10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evaninar must be notified at Annes.	Funeral Director	10e. Street and Number 20011 Mattingly 11. Marital Status	Cerrace 12. Was Decedent Ever	in U.S. 13.	10f. Zip Code Was Decedent of If Yes, specify Cu	20879 Hispanic Origin? (S ban, Mexican, Puer	Specify Yes or N	Unite	of What Cour ed Stat Race - Americ Black, White,	es
21215-0036	72 hours afte 'natural', or it dical Examin	Completed by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Ec (Specify only highest gra	1 Yes 2 No If Yes, Give Year or Dates: ucation de completed)	16a, Dece	1 ☐ Yes 2X No	Specify:	`	Spe		ite
nd 2121	12 should be filed within hand Mental Hygiene. 7 is marked other than "raumatic event, tha Me.	Be Compl	Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last)	College (1-4or 5+) 4 Josephus Mar	Bio1o	gist	e during most of wo	me (First, Middle		s Rive	r Labs
Maryland	and 2 should I saith and Meni n 27 is marke ier traumatic	To Be	Melchior Bali 19a. Informant's Name/Relationship (7 Betty Otten, Mothe	ype, Print)			Betty And Number or R	ural Route Numb	er, City or To		
Baltimore,	it. Pages 1 a rtment of Hei rtant: if item njury or othe		20a. Method of Disposition 1 XBurial 2 Cremation 3 X 4 Donation 5 Other (Specify 21. Signature of Finance Service Com-) Da	b. Place of Dispo cemetery, crea alton Je	esition (Name of matory or other plans) wish Cen	ace)	Date /02/04	20c. Location	on - City or To	own, State
Ba	Departicular Depar			lications that caused the d	death. Do not ent	orchinsk 54 Carro er the mode of dy	ess of Facility Y Hebrew 11 St., I ing, such as cardia	Funeral W, Wash correspiratory a	Home, ington	Inc.	20012 Approximate Interval Between
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	w requires that been signed should be det	þ	Part II. Other significant conditions of SEPTIC SHOUL		resulting in the u	nderlying cause g	ven in Part I.	23e. Did t			e cause of death? ably 4 □Unknown
of Vital Records,		Be Completed	25. Was case referred to medical				26. Place of Dea	24a. Was autoperfor 1 Yes	osy ormed? 220No	prior to com death?	osy findings available inpletion of cause of
Division of V	ding Phys h. After this funeral di	2	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Hospital: 1 Impatient 28a. Date of Injury (Month, Day Yea.	2 ER/Outpatien 28b. Time of Injury	28c. Inju	her: 4 🗆 Nursing H	ome 5 Residence	dence 6 🗆 C)
Divis	F te	sal Certification;	3 Suicide 4 Homicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Sp	knowledge, death	occurred at the t	ime, date and place	City or Tox	vn, State)	mannos as eta	Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29b. Signature and title of certifier	ner: On the basis of exame and manner stated.	nination and/or inv	29c. Licen	opinion, death occu	rred at the time,	date and place 29d. Date sign	ned (Month, D	the cause(s) Day, Year)
	10		30. Name and address of person who of RMH V. Bo	CIA MD	6420	Print) ROCKY	isda ; H	troo h		-	0817 WJ
	Sta Regist		31. Date filed (Month, Day, Year) MAR 0 1 20	32! Registrar's Si	gnature	Spark	al a			/	

			For State Registrer	of Maryland / D		artment of He tificate of D		Mental Hygie	201	4 08766
Æ	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Ye	3. Time of Death
1	/Medic	-Tr:		RIEN				FEBRUARY	25, 200	9:45 P ^M
	Examin	er	4a. Facility Name (If not institution, give street and	number)		4b. City, Town, or I		ath	4c. County of [
8.11 14.11	Funeval		1512 CALVERT ROAD 5. Social Security Number 6. Sex	7. Age (In yrs. last bird	thday)	CHESTI If Under 1 Year	EK If Under 24 Hr		9.	ANNE S Birthplace (State or Foreign
	Funeral Director		215-22-5011 ¹ X ¹ X ¹ X ¹ X ¹ X ¹ X ¹ X ¹	_	Yrs.	Months Days	Hours Mir	SEPT. 22,	ar)	Country) MARYLAND
	p ,		Usual Residence of Decedent	140-00-7						
	ehov	_	MD QUEEN ANNE S	10c. City, Town		cation				10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	the M	Director	10e. Street and Number	GHIDI		10f. Zip Code		100	Citizen of Miles	
	with		1512 CALVERT ROAD			21619			Citizen of Wha	t Country?
	death with the Maryland rms 23a or 28a-f ehow rmust be to diffed at	Funeral	11. Marital Status 12. Was	Decedent Ever in U.S.	13. \	Was Decedent of His	panic Origin? (Specify Yes or No-	USA 14. Race - A	American Indian,
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan f Heelth and Mental Hygiene. Item 27 Is marked other then "naturel", or items 23s or 28s-f show other traumatic event, I'm Mudical Exart est must be textilied at	þ	1 Never Married 2 Married 1 Yes	d Forces? es 2 ☐ No , Give or Dates:	1	f Yes, specify Cuban I□Yes 2🌠 No	, Mexican, Pue Specify:	nto Rican, etc.)	Black, V	WHITE
5-0	72 ho natur ilcal	Completed	15. Decedent's Education (Specify only highest grade comple			lent's Usual Occupat		ndking 16t	. Kind of Busin	ess/Industry
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	and 2 seeth ar n 27 is		COLLEEN THOMAS/DAUGHT			-		CT., STEVE		
Ē,	s 1 and the street of Hee		20a. Method of Disposition	20b. Place of	Dispo	sition (Name of natory or other place	Ţ			or Town, State
Ë	Page nent c int: If	Ш	1 Burial 2 □ Cremation 3 □ Removal for the Specify)	om State	-			28/2004 QU	EENSTO	IN MD
Baltimore,	permit. Pages 1 an Department of Heel Important: If Item 2 any injury or other once.		21. Signature J. Funeral Service Licensee	9/1	FF	Name and Address	of Facility LFENBE		FUNERA	L HOME, P.A.
			23a. Part 1. Enter the disease, or complications of shock, or heart failure. List only one cause	nat caused the death. Do r					2101	Approximate Interval Between
V	Physician	6 -	Immediate Cause (Final disease or condition	Respirator	N	failure				Onset and Death
1	/Medical		resulting in death)	to lut as a consequence		fibros				i
b	Examiner		Saguentially list randitions b.		arc	41000	515			
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Вох	death certificate be executed te attending physicien and od for use as the burial-transif	Physician/Me	IF FEMALE: 23c. If yes 23c. If yes	outcome of pregnancy					23d. Date of	delivery
0	death e atte	lcla	in the past 12 months?	ve birth 2 Fetal death regnant at time of death		Ectopic pregnancy Other (specify)			Month	Day Year
P.O.	ty the	hys	9 🗆 Onknown	nknown						
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ord	w requir been si shoufd	ted	n/A					1 Tes	2 No 3	Probably 4 Unknown
Division of Vital Records,	S CA	Completed	/* (* ` ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '					24a. Was an autopsy	prior	autopsy findings available to completion of cause of
T E								perförmed 1 ☐ Yes 253		h? Yes 2□ No
<u> </u>	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner? Hospital:			Othor		eath (Check only one)		
ō	Phys r this ral di	5	1 162 5 MINO	☐ Inpatient 2☐ ER/Ou ate of Injury 28b. 1	tpatien Time of		4 Nursing	Home Residence		Specify)
o	Attending I r death. ector: After by the funer	ţ	Natural 5 ☐ Pending (a		njury	28c. Injury : Work? M 1 🗆 Ye	5° 9s 2 ∐ No	200. Describe now in	njury occurred	
/ISI	of or Attendate death Director: /	ifica	a Could not be	lace of Injury - At home, fa uilding, etc. (Specify)	ırm, str			28f. Location (Street	t and Number o	r Rural Route Number,
Ö	s afte	Certification;	4 Hornicide	uilding, etc. (Specify)				City or Town, S	tate)	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical (29a. Certifier (Check only one) 1 Certifying Physician: To 2 Medical Examiner: On the and the control one)	the best of my knowledge ne basis of examination an nanner stated.	e, death	occurred at the time restigation, in my opi	, date and place nion, death occ	ce, and due to the cause curred at the time, date	a(s) and manne and place, and	r as stated. due to the cause(s)
	To the To the comp	W	29b. Signature and title of certifier Momo Wals	li mo		29c. License D23	867		2/27/	onth, Day, Year) O4
			30. Name and address of person who completed THOMAS WARSH MI	cause of death (Item 23a) (130 LOV) 2. Registrar's Signature 1 Material	(Type	Print) Ount ROAT	Ster	veus Ville.	MD 2	4666
	Sta	te	31. Date filed (Month, Day, Year)	2. Registrar's Signature	- /(111				
DL	Registr		FEB 2 7 20	O Blown	H.	Sparte				

Amend Item#1 per State of Maryland / Department of Health and Mental Hygiene O 14

For Phy. 3/12/04 State of Maryland / Department of Health and Mental Hygiene O 14

Reg. No. 08767 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Okronley Sr. 500 M **Physician** /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Hunder 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6 Sax 5. Social Security Number **Funeral** 15 M 2□ F 84 04/03/1919 Director 202-09-4546 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10a. State 10c. City, Town or Location 10b County rel', or items 23e or 28a-f ahow Examiner must be notified at Annapolis 1 ☐ Yes 2 No MD Anne Arundel Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Mith 21401 2052 Quaker Way, Unit 3 USA Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 Married WWT T. White 1 ☐ Yes 2 ☑ No Specify: Baltimore, Maryland 21215-0036 Completed by 3 ☐ Widowed 4 ☐ Divorced "naturel" or then "nature". It is Medical E 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Cook/Baker Gourmet Shops 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event QRGS. Victoria Krasiewska Bernard Okronley 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Anna M. Okronley/Wife 2052 Quaker Way, Unit 3, Annapolis, MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 03/09/2004 Crownsville, MD Veterans Cemetery A □ Donation 5 □ Other (Specify) 21. Signature 1 Funeral Pervi le Liq 22. Name and Address of Facility Farranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition HEAR T FAILURE CONGETIVE DAYS **Physician** resulting in death) /Medical **Examiner** CARDIUMYOPATHY 15 CHEMIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine INFALTION HOUL ! Hospital or Attending Physician: The law requires that the death certificate be executed MYDGARDIAL burial-tran Due to (or as a consequence of) Box 68760, attending physician Physician/Medical 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy Month Day in the past 12 months? 5 Other (specify) Yes 2 No P.O. 9 Unknown 9 Tillaknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Division of Vital Records, VOLVULUS 1 Yes 2 No 3 Probably 4 Unknown SIGMOID Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed director, page 2 : 1 ☐ Yes 2 ☐ No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 X patient 2 ER/Outpatient 3 DOA Certification: To 28c. Injury at Work? filled in by the funeral ate of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After 1 Natural
2 Ascident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 T Suicide 4 Homicide 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00051437 mn 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANNAPOLLI AAMC 1BITUYE DARCY OXEOWO 31. Date filed (Month, Day, Year) 32. Registar's Signature State MAR 0 8 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

			1 - For State RegistraAMEND ITEM	State of N	Maryland/I ER PHY G	Depar <i>&erti</i>	tment	of He	ealth a	ınd M		gieng Reg. No.	004	08768	}
	D1		1. Decedent's Name (First, Middle,		***************************************						2. Date of De	ath	Year	3. Time of Death	-
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}	Examir		4a. Facility Name (If not institution,				4b. City, To					4c. C	ounty of Death	EEORGE's	
			Renaissance G 5. Social Security Number	ardens@ _{Vi}	Ilage		Silv If Under 1		Spri		9. Date of Dir	Mo:		EORGE's	-
п	Funeral Director		068-10-4392	18 M 2□F				Days	Hours	Min.	8. Date of Bir (Month, Da Feb. 22	, 1911	Ma	nplace (State or Forei untry) Ssachusett	ign S
	D		Usual Residence of Decedent									•			
	arylar show	5	10a. State 10b. County PR]	NCE GEORGE	10c. City, Tow									10d. Inside City Limit	
	the M	Directo	Maryland Montgo	лист у	Silve	er sp						10- 01-		1 □ Yes 2∏N	
	n 72 hours after death with the Maryland "neturel", or items 23a or 28a-f show relical Examiner must be notified at		3160 Gracefield	Road, #123	10		10f. Zip C	209	04				nited :		
	er dez	Funeral	11. Marital Status	12. Was Deceder Armed Forces	?	13. Wa	as Deceder es, specify	t of His Cuban	panic Orig , Mexican,	jin? (Spe , Puerto I	city Yes or No Rican, etc.)	- 14	. Race - Amer Black, White		
36	I', or	by F	1 ☐ Never Married 2万 Marrie 3 ☐ Widowed 4 ☐ Divorced	d 1 ☐ Yes 2 € If Yes, Give Year or Dates	No :	10	Yes 2	No 5	Specify:			S	pecify: W	hite	
ò	2 hou		15. Decedent's	Education		. Deceder	nt's Usual C	Occupat	tion			16b. Kind	of Business/I	ndustry	
215	e. an "n	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4ol	5+)	life. DC	nd of work of NOT use	done du retired)	ıring most	of workir	ng				
21	ygien ygien yer th	Con	12		-4 El	ectr	onics						vate		
and	be fill	Be	17. Father's Name (First, Middle, La Augustus Pynn	ist)				· i			(First, Middle, Penne		umame)		
ž	hould d Mer marke martic	ဥ	19a. Informant's Name/Relationshi	(Tuna Print)	106	Mailing	Addraga /S				Route Number		Ct-4- 7	- 0. 4.1	
Maryland 21215-0036	od 2 s Ith an 27 is i		Frances T. Pynn											g,Md.20904	į
ē,	s 1 an f Heal ftem S	11	20a. Method of Disposition		20b. Place of	f Dispositi	ion (Name	of	1		ate		tion - City or T		_
OE.	Page on the page of the page o		1 ☐ Burial 2 ☑ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe				an Cr			3/1/	2004	Alexa	ndria.	Virginia	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygene. Important: if item 27 is marked other than "neturnary injury or other traumatic event, its Misdical once.		21. Signature of Funeral Service Li		. /										
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			23a. Part1. Enter the disease, or conshock, or heart failure. List or	omplications that cause nly one cause on each	ed the death. Do r line.	not enter	the mode o	f dying,	such as c	ardiac o	respiratory ar	rest,		Approximate Interval Between	
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Вох	eath certif attending for use as	by Physician/Med	23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 □ Ec	ctopic pregr	nancy				230	d. Date of deliv		
O.	Q 0 Q	/sici	1 Yes 2 No	4□Pregnant a 9□ Unknown	at time of death	5 🗆 O	ther (special	fy)					Month	Day Year	
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of Vital Record	w requir been si should	Completed									24a. Was			opsy findings available	
Re	Physicien: The lavithis certificate has al director, page 2	mo du									autop perfor	sy med?	prior to co death?	mpletion of cause of	·
ţa		a l	25. Was case referred to medical						26. Place o	of Death	1 ☐ Yes (Check only o	2X No	1 ☐ Yes	2□ No	
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<u>ا</u>	ing Pl		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inj (Month, D	ury 28b. T ay Year) Ir	Time of njury		Injury a Work?			Bd. Describe h				
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ā	lor At after of Direc	Certification;	4 Homicide determine	ad 286. Place of it	ijury - At home, fai tc. (Specily)	rm, street	, factory, of	fice		2	8f. Location (S City or Tow	treet and N n, State)	lumber or Run	al Route Number,	
lund .	Hospital 24 hours & Funerel I stely filled		29a. Certifier X Certifying	Physician: To the bes	of my knowledge	. death or	curred at t	he time	date and	place at	nd due to the o	ause(s) an	d manner as s	tated	
	To the Hospital or Attending Ph Within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medical	(Check only 2 Medical Ex	aminer: On the basis and manner s	of examination and	d/or inves	tigation, in	my opin	nion, death	оссигге	d at the time, o	ate and pla	ace, and due t	the cause(s)	
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	1		30. Name and address of person which Loveen Puthumana	o completed cause of 3110 Grac	death (Item 23a) (efield R	Type, Prir	ilver	Spi	ring,	Mar	yland 2	20904			
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			Registrar			Tillicale of i	Dealli	Re	g. No.	. 00705
	Physicia	an	Decedent's Name (First, Middle, La	a <i>st)</i>				2. Date of Death Month	Day Year	
	/Medic		Mary Jane	Pugh				February		
	Examin	er	4a. Facility Name (If not institution, gir				Location of Death		4c. County of De	1
			Montgomery Villa				ery Villa	age	Montgon	nery
	Funeral				ge (In yrs. last birthday	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. B	irthplace (State or Foreign Country)
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	<u>و</u> _		Usual Residence of Decedent		10.00					1.2.1.1.2.1.1.
	rylar	_	10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	B-f a	cto	Maryland Montgom	ery	Gaith	ersburg				1 ☐ Yes 2 ☒ No
	h th	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What (Country?
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	within 72 hours after death with the Maryland ene. than "naturel", or itams 23s or 28s-f show than "holical Exemiter most be notilised at	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp	Decify Yes or No-		nerican Indian,
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2	nin 7	ple	(Specify only highest gi	College (1-4or	life.	DO NOT use retired	t)	anig .		
21215-0036	d wit	Completed by		1	,	Secretary	7	F	ederal Go	vernment
	be filed within 72 hours after death with the Marylan hat Hygiene. Id other than "natural", or liams 23s or 28s-1 show avent. The Macifest Exercitive most be notified at	BeC	17. Father's Name (First, Middle, Las	t)			18. Mother's Nam	ne (First, Middle, M	faiden Sumame)	
<u>a</u>	ld be enta ked ked ic ev	To B	Lewis	Pugh				Josephi	ne B	rennan
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	Heal Heal		20a. Method of Disposition	.1/ Nephew	20b. Place of Disp	osition (Name of			Oc. Location - City of	
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39	permil Depar Impor any ir		21. Signature of Funeral Service Lice	insee (1)	UsU.	22. Name and Addre	D		eral Home	
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nstitution, give street and nur	mber)	4b. City, Town, or	Location of Death		4c. County	of Deeth		
General Hospi	ital	01n	ey		Mont	gomer	у	
r 6. Sex 1 M 2 ☐ F	7. Age (In yrs. last birthday) 69 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y Sept. 22,	1934	9. Birthpl Coun New	ece (State or Foreign try) Cork	
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County	10c. City, Town or Lo	cation				10	Od. Inside City Limits	

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Funeral

Director

1. Decedent's Name (Fir

death with the Maryland filed within 72 hours after permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "naturenty injury of other traumatic avent, In Medical Once. Pages 1 and 2 should be filed nent of Health and Mental Hygi ent: If Item 27 is markad other

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

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The law requires that the death certificate be executed

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death

within 24 hours a To the Funeral D

Division of Vital Records, P.O. Box 68760,

Examine Physician/Medical þ Completed Be Certification: To the filled in by Medical

Physician /Medical 4e. Fecility Name (If not i Examiner Montgomery 5. Sociel Security Number 057-28-0884 Usuel Residence of Deci 10a State 1 ☐ Yes 2 ☑ No Rockville Directo Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20853 United States 4525 Valley Forge Drive Funera 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 🗓 No Specify þ 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done di life. DO NOT use retired) during most of working Elementary/Secondary (0-12) College (1-4or 5+) Computer Technology Senior Systems Engineer 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Vida Mary Siegel Frederick Mathias Peters 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Barry F. Peters / Son 8404 Bradmoor Drive, Bethesda, Maryland 20817 20b. Place of Disposition (Name of 20c. Location - City or Town, State March 2, 20a. Method of Disposition cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 2004 Silver Spring, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20050-2005 21. Signature of Funeral Service Licenses M01305 23a. Part. The rithe disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Years Immediate Cause (Final disease or condition Metastatic Colon Cancer resulting in death) Due to (or as a consequence of). Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence off that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2□ No 2 No 1 ☐ Yes 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title 29c. License number

State

Registrar

DHMH 17 Rev 1/2001

32. Registrar's Signature

Beggeran

30. Name and address of person the completed cause of death (Item 23a) (Type, Print)

Joseph Kaplan, M.D. 31. Date filed (Month, Day, Year)

MAR 0 1 2004

18111 Prince Philip Drive, Olney, Maryland 20872 DONKS!

D35635

February 27, 2004

State of Maryland / Department of Health and Mental Hygiene Reg. No. 1 1 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death March 1',200 4°ar **Physician** 5:05a Anastasia Pappas /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 ☐ M 2 🕱 F 61 Yrs. 225-80-9011 Director 7/15/1942 Greece Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d, Inside City Limits 28a-f ahov traumatic event, the Mudical Examiner must be notified at MD Prince George' Greenbelt Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20770 6221 Springhill Court #203 USA Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural; or item any injury of pithar traumatic event, the Wadral Exc. inforce. Black, White, etc. ☐Yes 2 No Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ₹ No Specify: White Year or Dates: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Katherine Moros John Margaritis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 0 7 7 0 19a. Informant's Name/Relationship (Type, Print) Gus Pappas/Husband 6221 Springhill Court #203 Greenbelt, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 St Burial 2 □ Cremation 3 □ Removal from State
1 □ Donation 5 □ Other (Specify) 3/03/04 Silver Spring, Md Gate of Heaven 21. Signature Funeral Service Lic Ase PHILIP COLUMBIA BLVd. SILVER SERVICE, P. A. 9241 Columbia Blvd. Silver Spring, Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 6mo. Metastatic small cell lung cancer /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physician: The law requires that the death certificate be executed ed by the attending physicien and detached for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760 by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown as been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 X Yes 2 ☐ No 3 Probably 4 Unknown breast cancer Be Completed 24b. Were autopsy findings available prior to completion of cause of death? squamous cell carcinoma 24a. Was an has autopsy performed? Yes 2 No this certificate 2 No 1 ☐ Yes 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 X Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 Natural 5 Pending after death.

Director: Aft
d in by the fur М 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours at To the Funaral D Hospital 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D35996 3/01/04 llmo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Linda M.Burrell, MD2730 University Blvd Wheaton, Md 20902 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 03 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 200 L, 08772 1 - For State Registrar Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** olyn 200 /Medical 4a. Facility Name (IL not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Montgomery Silver Spring Cross Hospital Ho1y If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, July 7, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🔀 F 1942 Kentucky 61 220-40-5250 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State item 27 is marked other than "natural", or Itema 23a or 28a-1 show other traumatic event, the Medical Examinat must be notified at 1XYes 2 □ No Maryland Prince Georges Adelphi Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20783 U.S.A. 10100 Vireo Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours atter nent of Health and Mental Hygiene, and the filed Hygiene, and the filed To I marked other than "natural", or file ury or other traumatic event, I'm Mudical Exams any or other traumatic event, I'm Mudical Exams and 1 Never Married 2 Married Specify: White 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify þ 3 ☐ Widowed 4 ☑ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Residential Cleaning Cleaning 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mildred Eastep Edward Lee Hampton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 459 South Wisconsin Street, Fall Creek, WI 54742 Faucett/ Daughter Jeanne 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal Irom State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If eny injury or once. 3/4/2004 Waldorf, Maryland Huntt Crematory 4 □Donation 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Robert E. Evans Funeral Home 20715 16000 Annapolis Road, Bowie, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ardiovasc 7 days **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence ol): Examiner pirauthy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (of as a consequence bl) Examiner metastan c cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year Month in the past 12 months? 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 3 □ Probably 4 □ Unknown 1 ☐ Yes 2 D No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2□ No certificate 1 Yes 1 Tes Hospital or Attending Physicien: 25. Was case relerred to medical examiner? After this certific funeral director, Be 26. Place of Death (Check only one) 2 No Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3□ DOA 2 1 🗌 Yes 2 ER/Outpatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending To the hosping within 24 hours after death.

To the Funeral Director: Aft M 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗌 Suicide 28l. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 4 | Homicide 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier weshe MO D0060 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Candice Silvester, MD 1500 Forest Glen Road, Silver Spring, Maryland 31. Date liled (Month, Day, Year) 32. Registrar's Signature State 3 2004 Registrar

ORIGINAL

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2004 08773

						Certific	ate of	Death		Reg. No.	Πů	00113
	Physic	ian	Decedent's Name (First, Middle, L.	ast)					2. Date of De	eth Day	Year	3. Time of Death
- (/Medi				h Phillips					bruary 28,		6:15 P.M.
`	Exami	ner	4a. Facility Name (If not institution, gi	ve street and number)				4b. City, Town,	or Location of Deat	4c. County	y of Death	
			Social Security Number 6.	Egle Nursing F		Salara Millo	ider 1 Year	I If I Indox 24 I	onaconing		A	llegany
	Funeral			Sex 7.Age 1□M 227F	e (In yrs. last bi	Yrs. Mont			Hrs. 8. Date of Bir Min. (Month, Da	th y, Yea <i>r)</i>	9. Birthp Cour	place (State or Foreign ntry)
	Director		215-16-4127 Usual Residence of Decedent	<u> </u>	84	,			Jul	y 20, 1919		Maryland
	laryland show		10a. State 10b. County		10c. City, Tow	n or Location					1	0d. Inside City Limits
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	r 288	Director	10e. Street and Number	Allegany		10f.	Zip Code	Lonace	ning	10g. Citizen of	What Cour	ntry?
	3a o	<u>_</u>	20610 Ch	arlestown Road	CW			2152		•		_
	n 72 hours after death with the Maryland "natural", or Items 23a or 28a-f show adical Examinat must be nytified at	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	Ever in U,S.	13. Was De	cedent of	2153 Hispanic Origin	(Specify Yes or No	- 14. Rad	ce - Americ	JSA an Indian,
0	after or Ite	Ī	1 ☐ Never Married 2 ☐ Married	1 □ Yes 2 2 N			-		uèrto Rican, etc.)	Bla	ck, White,	etc.
9	ours Frail', o	þ	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ⊔ Yes	2 D No	Specify:		Specif	y:	White
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21	C F 39	ם	Elementary/Secondary (0-12)	College (1-4or 5-	+)	life. DO NO	Tuse retire	during most of	working			
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6	1 end Health em 27			illips -Son				85 Charles	town St., Lon	coning M	d. 2153	9
5	ges 1 end 2 should be filled tof Health and Mental Hyg If Item 27 Is marked othe or other traumatic event,		20a. Method of Disposition 1 ☐ Burial 2 🖫 Cremation 3 ☐	Removal from State	20b. Place o cemete	f Disposition (/ ry, crematory c	varne or		Date	20c. Location -	City or To	wn, State
틆	men men tant: jury		4 ☐ Donation 5 ☐ Other (Special			Cumberla	nd Cre	matory	March 01, 2004	Cu	mherlar	nd, Maryland
Baltimore,	permit. Pages i Department of H Important: If Ite any Injury or ot once.		21. Signature of Funeral Service Lice	nsee			and Addre	ss of Facility				•
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			23a. Part1. Inter the disease, or conshock, heart failure. List only	plications that caused to	the death. Do	not enter the m	ode of dyi	ng, such as card	St. Lonaconii diac or respiratory ar	ig Md.215. rest,	39	Approximate
	Physician	14	0				-				i	Interval Between Onset and Death
	/Medical Examiner		Immediate Cause (Final disease or condition	Res	pirato	7/y /	ail	ure			1	inorth
	Lxaminer	L	resulting in death)	a	Due to (or as a	consequence	of):	1	,	A	1	10 years
	ed isit	Examiner		a. Res	enic c	15/16	Ictiv	e ful	monger,	Disease		10 years
	certificate be executed nding physician and use as the burial-transit	xan	Sequentially list conditions, if any, leading to immediate		oue to (or as a							
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<u>о</u> .	Physicien: The law requires that the death this certificate has been signed by the atternal director, page 2 should be detached for	by Physicia	Part II. Other significant conditions of	1.	not resulting in	the underlying	g cause giv	en in Part I.			ntribute to	the cause of death?
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<u></u>	eral c	Ë	27. Manner of Death	28a. Date of Injury	28b. T	ime of	28c. Injur Wor	4 LOS INUISING	Home 5 Resid)
5	afing tth.: Afte	탏	1. ■ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year) In	njury M		k? Yes 2 □ No		, , , , , , , , , , , , , , , , , , , ,		
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בֿ	al or A s after al Direction b	Certification:	4 - Homicide	building, etc.	(Specify)				City or Tow	n, State)		
	ospit hour unera		29a. Certifier 1 Certifying Ph	ysician: To the best of	my knowledge	, death occurre	d at the tin	ne, date and pla	ce, and due to the c	ause(s) and ma	nner as sta	ited.
	To the Hospital or A within 24 hours after A To the Funeral Director Completely filled in b	edical	(Check only 2 Medical Exan	niner: On the basis of e and manner state	xamination and	z/or investigation	on, in my o	pinion, death oc	curred at the time, d	ate and place, a	ind due to t	the cause(s)
	Vith Vith Eog	Σ	29b. Signature and title of confider	E) /	7		9c. Licens			9d. Date signed		
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r	1123		30. Name and address of person who	completed cause of dea	ath (Item 23a) (Type, Print)	1	Λ				1 21539
	11 000		Thomas J	pevin	MU	20 10	ugla	5 AVE,	60140	oning	, M	1 21539
	Sta Registra		31. Date filed (Month Day Year) 201	32. Registrar	's Signature							

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2.2.2.4

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	Physici /Medic		1. Decedent's Name <i>(First, Mi</i> Harold	ddie, Las	-	Wats	on		Davis		2. Date of De Month March	Day	04 Year	3. Time of Death 10:30 PM	
Σ	Examir		4a. Fecility Name (If not instituted as Cumberland							4b. City, Town, or L Cumberlar					
	Funeral Director		5. Social Security Number 217-18-4841	6. S	0	7. Age	(In yrs. last bin	thday) Yrs.	If Under 1 Year Months Days		8. Date of Bir (Month, Da 05/11/	Alleg Birth 9. E Pay, Year) 9. E 1923 W		thplace (State or Foreign ounity)	
	פ		Usual Residence of Decedent 10a. State 10b. Cou	th.			10c. City, Town	n or Loc	eation					10d. Inside City Limits	
	hours after death with the Maryland urel', or litems 23a or 28e-f show al Examiner must be notifiled at	ō		"y lega	nv			Cumberland					1 🛣		
	7 28e-	Funeral Director	10e. Street and Number	1054				211100	10f. Zip Code			10g. Citize	en of What Co	ountry?	
	th with	al D	814 Rayne D	rive					21502			U	SA		
	ems erm	ıner	11. Marital Status		12. Was Dec Armed F	edent Ev	ver in U,S.	13. W	as Decedent of I	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.))- 14	4. Race - Ame Black, Whit		
N N	s afte	by Fu	1 ☐ Never Married 2 ☒ M 3 ☐ Widowed 4 ☐ Divord		1 🔼 Yes If Yes, Gi	2 □ No ve	1941-		□Yes 2ŽNo				Specify: Wh		
0200-61212	2 hour	Completed b	15. Dece	ent's Ed	Year or E ucation		1946	ent's Usual Occup	pation			of Business			
دار 12	be filed within 72 hours after death with the Marylan Hygiene. At Hygiene. At the medical Examiner mast be notified at event, it a Medical Examiner mast be notified at		(Specify only hig Elementary/Secondary (0-12	hest grad	de completed) College ()			pation during most of work d)	ing			,	
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yland	be fill Hy ad oth even	Be	17. Father's Name (First, Midd George	le, Last)	Ні	ller	37	D	avis	18. Mother's Nam Susan	e (First, Middle		<i>umame)</i> plinge	r	
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Mar	D = N =	r H	Helen Davis /				19b. Mailing Address (Street and Number or Rural Route Number, City or Town 814 Rayne Drive, Cumberland, MD 21							<i>LIP</i> 0000)	
e,	is 1 and of Health Item 27 other tr		20a. Method of Disposition				20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State								
Ē	Page nent c		1 ☐ Burial 2 ☐ Crematic 4 ☐ Donation 5 ☐ Other			State					03/05/	2004	Flint	stone, MD	
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23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line. Physician /Medical Immediate Cause (Final											or respiratory a	rrest,		Approximate Interval Between Onset and Death	
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JINISI	or Attencester death	Certification:	3 Suicide 6 □ Cou	stigation d not be rmined	289. Place	of Injury	y - At home, fai (Specify)	rm, stre	et, factory, office		28f. Location (5 City or Tox	Street and I vn, State)	Number or Ru	ural Route Number,	
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	HLS		30. Name and address of personal PETER	on who c	CMS L		ath (Item 23a) (Type, P	FY ST.	Cumber Cumber	uland,	Md	215	32	
	Sta Registr		31. Dete filed (Month, Day, Ye MAR 0 3 20)		32. F	legistrar	s Signature	do	nds						

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State of Maryland / Department of Health and Mental Hygiene? 0.01

			1 = For State Registrar	State of Maryland	Cer	tificate of L	Death	Re	g. No.		
ŗ	Physicia	4	1. Decedent's Name (First, Middle, Last) FRANCIS MAXWELL PH	1 FER				2. Date of Death Month FEBRUARY	Day Yee	0 14	
	/Medic Examin		4e. Fecility Name (If not institution, give s	treet and number)			Location of Death		4c. County of D	eeth	
<u>à</u>	Çiriş. .k		HEARTLAND HOUSE 5. Social Security Number 6. Sex	7. Age (In yrs. I	aet hirthday)	GRASONV If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	QUEEN A		
	Funeral Director		0. 000	M 2□F 95	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, JUNE 18,	1908 N	Birthplece (State or Foreign Country) EBRASKA	
	yland Now		10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits	
	e Mar	Director	MD QUEEN AN	NE'S GR	ASONVI					1 ☐ Yes 2 X No	
	or 28	Dire	10e. Street and Number			10f. Zip Code		10	g. Citizen of What	Country?	
	eath v	eral	113 PERRY CORNER R	OAD 12. Was Decedent Ever in U.	S. 13. \	21638 Was Decedent of Hi	spanic Origin? (Sp	ecify Yes or No-	USA 14. Race - A	merican Indian,	
920	within 72 hours after death with the Maryland ane. then 'natural', or Items 23a or 28a-f ahow the Mudisal Exems for much the notified at	by Funeral	1 Never Married 2 Married 3 X Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:	S. 13. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ▼ No Specify:			Rican, etc.)	Black, W	/hite, etc. WHITE	
5-0	72 ho 'natur	eted	15. Decedent's Educ (Specify only highest grade	cation completed)	ion (Give kind of work done during most of wo			16b. Kind of Business/Industry			
12	within ane. then	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		TRICIAN)		FEDERAL	GOVERNMENT	
р Б	be filed tal Hygi d other event, t	Be Cc	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, M	aiden Sumame)		
<u> a</u>		To B	CHARLES PHIFER				DAISY B	ISHOP			
Maryland 21215-0036	nd 2 should lith and Menith 27 is marker traumatic		19a. Informant's Name/Relationship (Type GAIL RANKIN/DAUGHT			OVE ROAD,			City or Town, Stat 21658	e, Zip Code)	
Baltimore,	Pages 1 and nent of Health int: If Item 27 ury or other tr		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State	emetery, cren	sition (Name of matory or other place	θ)		Oc. Location - City STEVENSV		
Balti	permit. I Departm Importar any inju		21. Signature of Funeral Service License		FI		ELFENBEIN	& NEWNAI	M FUNERAI	L HOME, P.A.	
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the death						Approximate Interval Between	
,	Physician		Immediate Cause (Final disease or condition	(PNIGETIV	6 1/0	ERCT FA	JURG			Onset and Death	
	/Medical Examiner		resulting in death)	Due to for as a consequ	uence of):	1 + 1	7 1				
	LXUITITICI	70	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence)	uence of):	LEAS! W	Blen)			
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	Renal 1	Renal Insufficient						
oʻ	ficate be executed g physician and is the burial-transit		resulting in death) Last								
68760,	ate be shysici the bu	edical				10	4				
	E On a		IF FEMALE: 2	3c. If yes, outcome of pregna	ncy				23d. Date of	delivery	
Box	that the death certified by the attending detached for use as	by Physiclan/M	23b. Was decedent pregnant in the past 12 months?	1☐Live birth 2☐Fetal 4☐Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)			Month	Day Year	
Ö.	t the	hysi	9 Unknown	9 Unknown							
s, p	w requires that s been signed I should be det	by P	Part II. Other significant conditions con	tributing to death but not resi	ulting in the u	nderlying cause give	en in Part I.			e to the cause of death?] Probably 4Unknown	
ord	requir een s hould	eted						-	1000000		
Vital Record	e la has	Completed						24a. Was an autopsy perform	prior	a autopsy findings available to completion of cause of 1?	
a		e Co	25. Was case referred to medical				26 Place of Dogs	1 Yes 2 h (Check only one	10\no	/es 2□No	
	Physician: this certific ral director,	To Be	evaminer?	lospital: 1 Inpatient 2	ER/Outpatier	nt 3 DOA Othe	ne:	ome 5 Resider		Specify)	
Division of	ding After fune		27. Manner of Death 1. Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	f 28c. Injury Work	at at	28d. Describe hov			
Divisi	l or Attendater death Director;	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify		reet, factory, office		28f. Location (Stre City or Town,	eet and Number of State)	r Rural Route Number,	
•	To the Hospitel or Attentwithin 24 hours after deatl To the Funeral Director: completely filled in by the	edical C		sician: To the best of my kno ner: On the basis of examina and manner stated.							
	To the within 2. To the Complet	Me	29b. Signature and title of certifier	,01	/	29c. License	e number	29	d. Date signed (M	onth, Day, Year)	
			Jelf X/, W	Mullen		DOG	2705	S	3-2-01	1	
			30. Name and address of person who co			Print)	1	.0.1	4	wille, md	
	Sta) to	31. Date filed (Month, Day, Year)	_ Xersov 32. Registrar's Signa	204 ture	onedic	el GR	· Kd.	raso	well, Md	
	Regist		MAR 0 4	797	18	Aneste.					

State of Maryland / Department of Health and Mental Hygiene 2004 08776 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician A^{M} Mary R. Rutledge February 27,2004 3:20 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Olney
| If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | Montgomery General Hospital Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 ☑ F Yrs. Director Dec.23,1922 577-24-0128 81 Colorado Usual Residence of Deceden with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Silver Spring Maryland | Montgomery 10e Street and Number 10f. Zio Code 10g. Citizen of What Country? Leisure World Boulevard 3591 South 20906 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☑ No þ Specify: 3 ₹Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 rmit. Pages 1 and 2 should be filed w partment of Health and Mental Hygier popratni: If Item 27 is marked other th y Injury or other traumatic event, Ilm EGS. Fire Industry Bookkeeper othert 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ဂ George Renkel Elizabeth Schrieber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Moores Silver Spring, Maryland 20905 Daughter 14412 Sturtevant Road Baltimore, 20b. Placs of Disposition (Name of cometery, crematory or other place)
Metropolitan
Crematory 20a. Method of Disposition 20c. Location - City or Town, State Department o important: If any injury or 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Feb. 28, 2004 Alexandria, Virginia 22. Name and Address of Facility
Francis J. Collins Funeral Home, Inc. 21. Signature of Funeral Service L 5 amo 500 University Blvd., W., Silver Spring, MD 20901 23a. Parti Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** 2 months a End Stage Chronic Obstructive Pulmonary Disease /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and the burial-transit death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical as use IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy õ in the past 12 months? Month Year Day 5 Other (specify) P.O. detached 1 ☐ Yes 2 反 No the 9 Unknown The law requires that the ģ signed l Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, pe Completed Atrial Fibrillation 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 Tes 2 TNo Attending Physician: funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 🔀 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After To the Hospitel or Attending within 24 hours after death.
To the Funerel Director: Afte completely filled in by the fun 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) February 27, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. Ozanne-Blankford, 3305 N. Leisure World Boulevard Silver Spring,MD 20906 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 0 1 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Russell **Physician** Dorothy February 28, 2004 5:18 /Medical 4a. Facility Name (If not institution, give street and number) Montgomery General Hospital 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 01ney Montgomery | If Under 1 Year | If Under 24 Hrs. | B. Date of Birth | Min. | May 8, 1931 5. Social Security Number 7. Age (In yrs. last birthday) 72 yrs. 6. Sex Birthplece (State or Foreign Country) **Funeral** 1 □ M 2 🗓 F 205-22-7171 Yrs. Director Pennsylvania Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "neturet, or items 23a or 28a-f show enty injury or other traumatic event, if a Madical Examinat must be notified at once. 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 01ney Maryland Montgomery Director 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3413 Colonial Court 20832 United States Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) Real Estate Real Estate Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Wilbur Tomlinson Edna Lukert ို 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Russell (Husband) 3413 Colonial Ct., Olney, Md. 20832 20b. Place of Disposition (Name of cemetery, crematory or other place) March 2, 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Chesapeake Crematory 2004 Beltsville, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, Md. 20910 eun Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** OvariAW CANCER disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated associated) Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 1 9☐ Unknown 9 Unknown s been signed by should be detailed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 2 X No 3 Probably 4 □Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? Yes 2 No certificate 1□ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 V Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA this After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending death. investigation 1 ☐ Yes 2 ☐ No Director: , 6 ☐ Could not be 3 Suicide within 24 hours after de To the Funeral Direct completely filled in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of contine 29c. License number 29d. Date signed (Month, Day, Year) February 28, 2004 D 39190 30. Name and address of person who completed cause 1 th (Item 23a) (Type, Print) Joseph Garrett Reilly, M.D.; 3418 Olandwood Ct., #111, Olney, Md. 20832 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Repende MAR 0 5 2004 Registrar

			1 - For State Registrar	State of	Maryland	d / Depa <i>Cei</i>	artment of rtificate o	Health ar f Death	nd Mental I	Hygien	e200	4 08778	
	Physici /Medi		1. Decedent's Name (First, Middle, Virginia	,	binson				2. Date of Month Febru	Da	ay Yea 27, 200		
•	Examir		4a. Fecility Name (If not institution, Manor Care Poto		ber)			or Location of Omac		40	c. County of De	eath	
	Funeral Director		5. Social Security Number 577-10-5218 Usual Residence of Decedent	3. Sex 1 □ M 2 🔀 F	7. Age (In yrs. Ia 97	st birthday) Yrs.	If Under 1 Year Months Day		Min. 8. Date of (Month) May 3	Birth Day, Year , 190	9. E	Birthplace (State or Foreign Country) West Virginia	
death with the Manyland	r 28a-f ehow notified at	Director	10a. State 10b. County	omery		Town or Lo)		10g. C	itizen of What	10d. Inside City Limits 1 Tyes 2 No Country?	
9	ial hygiene. d other then "naturel", or Iteme 23e or 28a-1 ehow event, the Medical Exameter must be notified at	Funeral	4908 Baltan Rd. 11. Marital Status t \(\sum \) Never Married \(2 \sum \) Married	12. Was Deced	2X No	ł		f Hispanic Origin Joan, Mexican, F	n? (Specify Yes or Puerto Rican, etc.)	No-	U.S.A. 14. Race - Ar Black, Wi	mencan Indian, hite, etc.	
Z I Z I 3-UUSO d within 72 hours after	n "naturel", o Medical Exur	Completed by	3√ Widowed 4 □ Divorced 15. Decedent's (Specify only highest Elementary/Secondary (0-12)	If Yes, Give Year or Da Education grade completed)	les:	16a. Deced	lent's Usual Occ kind of work dor OO NOT use reti	upation le during most o	of working	16b. F	Specify: White 16b. Kind of Business/Industry		
	Mental Hygiene. narked other then " natic event, the Me	Be	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumam								•	me	
Mary nd 2 shoul	permit. Pages 1 and 2 should b Department of Health and Ments Importent: If Item 27 Ie merked eny injury gowher treumatic e one.	7	19a. Informant's Name/Relationship J. Leslie Robin		Son			et and Number o	or Rural Route Nu	mber, City		, Zip Code)	
Saltimore, permit. Pages 1 ar			20a. Method of Disposition 1										
Dall permit.	Departi Importi eny inj		21. Signature of Funeral Service Lie	Xel	M01		TOO MISC	JOHSTH A	Joseph G	wasn	's Son	s, Inc. , DC 20016	
//	ysician Medical aminer	er	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) A. Hypertension Due to (or as a consequence of): Gastrointestinal Bleeding Due to (or as a consequence of): Cause (Disease or injury) Dementia									Approximate Interval Between Onset and Death	
The law requires that the death certificate be executed	attending physician and for use as the burial-transit	dical Examiner	resulting in death) Last										
the death certific	y the attending piched for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown		th 2 Fetal d nt at time of dea	leath 3 🗌	Ectopic pregnan Other (specify)	су		-	23d. Oate of d Month	elivery Day Year	
w requires that	been signed by the should be detached	by	Part II. Other significant conditions	s contributing to dea	th but not result	ing in the un	derlying cause g	riven in Part I.				to the cause of death? Probably 4 X Unknown	
cian: The lawr	is certificate has bu director, page 2 sh	e Completed	25. Was case referred to medical						pe 1 □ Ye	topsy informad? s 2 No	prior to death?		
ng Physi	fter this	To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigat	28a. Date of (Month,		R/Outpatient 8b. Time of Injury	28c. Inju	ther: 4X Nursir	Death (Check onling Home 5 Re 28d. Describ	sidence		ecify)	
ital or Att	D 00 C	Certification:	3 Suicide 6 Could not determine	ed 289. Flace o	f Injury - At hom , etc. <i>(Specify)</i>				City or	Town, State)	Rural Route Number,	
the Hosp	within 24 hours after 10 the Funeral Discompletely filled in	Medical	one) 2 Medicel Ex	Physician: To the b aminer: On the bas and manne	is of examination	edge, death in and/or inv	estigation, in my	opinion, death o	flace, and due to the control of the time	e, date and	d place, and du	e to the cause(s)	
O.			29b. Signature and title of certifier	abus			D357	792			29d. Date signed (Month, Day, Year) March 1, 2004		
			30. Name and address of person was Swaroop G. Ra	o, M.D.	50 Edmo	nston		04 Rock	cvill, MD	208	352		
	Sta Registr	-	31. Date filed (Month, Day, Year) MAR 0 4 2		jistrar's Signatur	6	Spork.	21					

State of Maryland / Department of Health and Mental Hygien 2 1 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 26, **Physician** February 2004 12:05 AM Christine Rafferty /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Deeth 4b. City, Town, or Location of Death Examiner Manor Care Potomac Potomac Montgomery 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 1 F 84 1919 England 028-05-0698 Director Usuat Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County or 28a-f ahow the Medical Examiner must be notified at 1 ☐ Yes 2 No Funeral Director Well Fleet Mass. Barnstable 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 35 Henry Doane Lane 02667 "natural", or itama 23a U.S.A. death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White ģ 3 Nidowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry othar than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w
Department of Health and Mental Hygier
Important: if item 27 is marked other th
any njury or other traumatic event, that
any njury or other traumatic event, that Waitress Banquet 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Ellen Hughes Patrick Kennedy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7400 River Falls Dr. Potomac, MD 20854 James Rafferty/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State Mar. 3, 2004 West Roxbury, MA 4 ☐ Donation 5 ☐ Other (Specify) Mt. Hope Cemetery 22. Name and Address of Facility Joseph Gawler's Sons, Inc. 5130 Wisconsin Ave., NW, Washington, DC 21. Signature of Funeral Service License leling 20016 M01296 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Myocardial Infarction 1 Hour disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** 20 Years Coronary Artery Disease Fecunitally list conflicts if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner I or Attending Physician: The law requires that the death certificate be executed after death.

Director: Atter this certificate has been signed by the attending physician and in by the timeral director, page 2 should be detached for use as the burial-transit in by the timeral director, page 2 should be detached for use as the burial-transit. Diabetes Mellitus Type II 30 Years resulting in death) Last Due to (or as a consequence of) Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year Month 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 XNatural 5 Pending investigation Injury 1 Yes 2 No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) lilled in by 4 Homicide within 24 hours a To tha Funeral C 29s Catiflet to Certifying Physician: To the bast of my knowledge, Jeath occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ANathorn MD D0053615 February 27, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11125 Rockville Pike, #208, Rockville, MD 20852 Aruna Nathan, M.D.

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

MAR

32. Registrar's Signature

2004

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Amend Item#28a per Phy. State of Maryland / Department of Health and Mental Hygiene AACo. Health Dept. 3/8/04 BEM Certificate of Death 2. Dete of Death 1. Decedent's Name (First, Middle, Last) Dey Year **Physician** Katherine Μ. Riedel February 29, 2004 8:04 AM /Medical 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Doctor's Community Hospital Prince Georges Lanham If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** Months Days 1 □ M 2 💢 F 218-34-7262 93 Director July 5, 1910 | Maryland Usual Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours efter death with the Marylan Department of Health and Mentel Hygiene.
Important: If Item 27 is merked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Prince Georges Glenn Dale Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 7825 Northern Avenue 20769 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race · American Indian. Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: Ś 3 Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Correspondence Department National Geographic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edwin Mobray Katie Clark 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley Specht/ Daughter 7825 Northern Avenue, Glenn Dale, Maryland 20769 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State emetery, crematory or other place)
rst Lutheran Church
Cemetery 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bowie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2004 22. Name and Address of Fecility Robert E. Evans Funeral Home 21. Signature of Fundral Service License 16000 Annapolis Road, Bowie, Maryland 20715 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) Physician/Medical Examiner choude Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or es e consequence of): Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 🗆 Yes 2 1 No 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 28a. Dete of Injury (Morth, Day 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Netural 5 Pending investigation 1 Yes 2 100 2 Accident 6 Could not be determined 3 Suicide Ple of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number,

Examiner Hospital or Attending Physician: The law requires that the death certificata be executed Box 68760. P.0. of Vital Records, To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this completely filled in by the funerel dir Division

death with the Maryland

Baltimore, Maryland 21215-0020

	City of Town, State)
	The second secon
d place	and due to the cause(s) and manner as stated.

er 1 Certifying Physician:	To the best of my knowledge, death occu	rred at the time, date and place, and due to th	e cause(s) and manner as stated.
cony 2 Medical Examiner: O	n the basis of examination and/or investigated manner stated.	ation, in my opinion, death occurred at the time	a, date and place, and due to the cause(s)
all	id marmer stated.		
ure and title of pertifler,	(1) (1)	29c. License number	29d. Date signed (Month, Day, Year)
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O Name	en eddress of	nerson who complet	d cause	of death (Item 23e) (Tu	ne Print)

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30. Name en eddress of p	erson who com	plet d ceuse of	deeth (Item 23e) (Ty	pe, Print)	1
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2000	1-00 11	110	1300	100000	rredy
31. Date filed (Month, Day,	Year)	32. Registi	rer's Signature		
3.5.0.10		1000			4

31. Date filed (Month, Day, Year) MAR 0 2 2004

4 Homicide

29a. Certifier

29b. Signat

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DHMH 16 Rev 6/95

State Registrar

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene 2 0 0!

		For State Registrar	State of Maryland	Cei	tificate of Dea	ath		. No.	08/82
Physici	an	1. Decedent's Name (First, Middle, Las	1)				2. Date of Death Month	Day Year	3. Time of Death
/Medic	cal	David Le 4a. Facility Name (If not institution, give			4b. City, Town, or Local	tion of Death	FEBRUARY	27, 2004 4c. County of Death	2235 P M
Examir	ier	118 HOOKER STREET	Street and Humbery		OAKLAND			GARRETT	
Funeral Director		220-58-0314	7. Age (In yrs. la XM 2 F		If Under 1 Year If Un Months Days Hou	nder 24 Hrs. urs Min.	8. Date of Birth (Month, Day, Yo)ec. 18,	9. Birthp Cour 1951 Ma	lace (State or Foreign try) ryland
tand		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation			1	0d. Inside City Limits
Mary a-f sho	tor	MD Gar	rett		Deer Pa	rk			1⊈Yes 2□No
or 28.	Funeral Director	10e. Street and Number			10f. Zip Code		10g	. Citizen of What Cour	itry?
sath w	erai	118 Hooker St.	12. Was Decedent Ever in U.S	13 1		1550 c Origin? (Spe	cify Yes or No-	14. Race - Americ	
ife, IMATYIATIO ZIZIO-0050 I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygene. Ifeaith and Mental Hygene. Item 27 is marked other then "naturel", or items 23s or 28s-1 show other traumatic event, the Medical Examiner must be notified at	by Fun	1 Never Married 2 Married 3 Widowed 4 ADivorced	Armed Forces? 1 ∐Yes 2 X No If Yes, Give Year or Dates:		Nas Decedent of Hispani f Yes, specify Cuban, Me 1 ☐ Yes 2점 No Spe		Rican, etc.)	Black, White, Specify: Wh	etc. ite
d within 72 hours at giene. Ir then "naturel; or the Wedt al Example.	eted	15. Decedent's Ed (Specify only highest gra-	ucation de completed)	(Give	dent's Usual Occupation kind of work done during	most of working	ng 16	b. Kind of Business/In	dustry
within sne.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired)			D D1	
nd < 1 < 1 1 1 1 1 1 1 1 1	a l	12th 17. Father's Name (First, Middle, Last)			Superviso 18. A		(First, Middle, Ma		t Operation
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Maryia d 2 should th and Men th and Men traumatic traumatic		19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailir	ng Address (Street and N	umber or Rura	l Route Number, C	City or Town, State, Zip	Code)
ore, IV		Timothy L. Rounds 20a Method of Disposition	20b. Pl	ace of Dispo	looker St.,	Decr Pa	ark, Md.	21550 c. Location - City or To	wn, State
ages int of th		1 △Burial 2 □ Cremation 3 □ '4 □ Donation 5 □ Other (Specify	Removal from State	metery, crei	natory or other place) Cemetery	3/2/		Swanton, M	
Daltimor permit. Pages Department of t Importent: if ite eny injury or of		21. Signature of Funeral Service Licen			2. Name and Address of F	Taville		enral Home	
Dermi Depa Impo		1 Scally 16.	Lion		2 S. Second	St., (akland	Md. 21550	
		23a. Part1. Enter the disease, ir companies shock, or heart failure. List only	plications that caused the death one cause on each line.	. Do not ent	er the mode of dying, suc	ch as cardiac o	r respiratory arrest		Approximate Interval Between Onset and Death
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/Medical Examiner		1	Due to (or as a consequ	ience of):					
	ĕ	Sequentially list conditions, if any, leading to immediate cause. Enter Uncertying Cause (Disease or injury that initiated events	b. Due to (or as a consequ	ence of):					
ocuted nd transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c						
be exe	Ë	resulting in dealiny cast	Due to (or as a consequ	ience or):					
58 / 50, tificate be executed g physician and as the burial-transit	edicai		. d						
BOX (eath certing attending for use a		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna		Ectopic pregnancy			23d. Date of delive	
b death	sicla	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time of de		Other (specify)			Month	Day Year
Cords, F.O. BOX wrequires that the death cer been signed by the attendin should be detached for use	by Physician/N	9 Unknown Part II. Other significant conditions c	ontributing to death but not resu	ilting in the u	nderlying cause given in I	Part I.	23e. Did tobac	cco use contribute to ti	ne cause of death?
Hecords, he law requires t e has been signe sge 2 should be							1 🗆 Yes	2√No 3□Prob	ably 4 Unknown
aw req	olete						24a. Was an autopsy	24b. Were auto	psy findings available mpletion of cause of
The law ate has b	Completed						performe	d? death?	2 No
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ital or rel Div			1	At	home			street, oa	
To the Hospital or A within 24 hours after to the Funerel Direct completely filled in by	edical	29a. Certifier 1 Certifying Ph (Check only Medical Examone)	ysician: To the best of my kno- niner: On the basis of examinal and manner stated.	wledge, deat ion and/or in	h occurred at the time, da vestigation, in my opinion	ate and place, a n, death occurr	and due to the caused at the time, date	se(s) and manner as s and place, and due to	tated. the cause(s)
ro the vithin of the complex	₩ We	29b. Signature and title of certifier			29c. License num			I. Date signed (Month,	
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1		30. Name and address of person who				Dol+	imoro M	maland 010	01
	ata	31. Date filed (Month, Day, Year)	32. Registrar's Signa		Penn Street	, Bdlt	шюте, Ма	пулаки 212	ΩŢ
Regist	ate trar	MAR - 3	2004		Coolles				
DHMH 17 Rev 1/3	2001								

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	Physici		1. Decedent's Name (First, Middle, La Kathleen Fay S			2. Date of Death Month FEBRUARY	Day Year	3. Time of Death	
	/Medic Examin	4	4a. Facility Name (If not institution, gi		4b. City, Town, or Location of Death		4c. County of Deat		
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	Funeral			Sex 7. Age (In yrs. last birthda)	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birti	Birthplace (State or Foreign Country)	
Ž.	Director		577-82-7448	1□M 2√2F 41 Yrs.	Working Days Hours IVIIII	May 24,		yland	
/	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or	Location			10d. Inside City Limits	
	sho	ក						1 ☐ Yes 2 ☐ No	
	28a-f	Director	Maryland Prince 10e. Street and Number	George's Beltsvi	1 1 L L E	10	g. Citizen of What Co	untry?	
	with B or		4607 Sellman Ro	and	20705		USA		
	heath ma 23	era	11. Marital Status	12. Was Decedent Ever in U.S. 13	3. Was Decedent of Hispanic Origin? (Sp	pecify Yes or No-	14. Race · Ame		
36	72 hours after death with the Maryland natural', or Itama 23a or 28a-f show dical Exaculator must be notified at	by Funeral	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:	o Rican, etc.)	Specify: White		
21215-0036	C	Completed by	15. Decedent's E (Specify only highest g	rade completed) (Giv	cedent's Usual Occupation we kind of work done during most of work . DO NOT use retired)	king	6b. Kind of Business/	ndustry	
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	2 should be filed within and Mental Hygiene. Ie marked other than aumatic event, the M	BeC	17. Father's Name (First, Middle, Las			ne (First, Middle, M			
lan	buid be Mental arked o	To B	Herschel Norma	n Ramsev	Eunice	Kate Wil	liams		
Maryland	should nd Men marke umatic	-	19a. Informant's Name/Relationship		iling Address (Street and Number or Ru			ip Code)	
	1 and 2 Health a am 27 le		Eunice Ramsey/ M	other 970	9 Grayson Avenue, S	Silver Sp	ring, MD	20901	
ē,	s 1 a of Hear itam othe		20a. Method of Disposition	20b. Place of Dis	position (Name of rematory or other place) Mar	ch, 2,	toc. Location - City or	Town, State	
Ë	Pages nent of I		1 ☐ Burial 2 ☑ Cremation 3 1 ☐ Donation 5 ☐ Other (Spec		Litan Crematory 2	004	Alexandria	, Virginia	
Baltimore,	permit. Pages 1 and Department of Health Important: If item 27 any Injury or other fr		21. Signature of Funeral Service Lice	Home Inc. ilver Spri:	ng, MD 20901				
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Вох	ath ce Itend or use	lan/	23b. Was decedent pregnant in the past 12 months?		3 □Ectopic pregnancy		23d. Date of del	very Day Year	
	e deg the a	Sic	1 Yes 2 No	4□Pregnant at time of death 5 9□Unknown	5 Other (specify)				
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ds,	w requires that been signed to should be det	by			, - -	1 □ Ye	s 2. No 3 □ Pr	obably 4 Unknown	
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ec.	e law has l	Jq.				autopsy perform	/ prior to d	topsy findings available completion of cause of	
E F	: The cate his page				· · · · · · · · · · · · · · · · · · ·	19 Yes 2	□ No 1 2 Yes	2□ No	
Vit.	ician certifi ector	Be	25. Was case referred to medical examiner?	Hospital:	Othors	th (Check only one			
of	Physician: r this certificinal director,	J.	12 Yes 2 No 27. Manner of Death	1 ☐ Inpatient 2 ☑ ER/Outpati	Herit 30 DOA 40 Nursing H	lome 5 Reside 28d. Describe ho	nce 6 Other (Spec	city)	
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isi	Attending r death. ctor: After by the fune	ca	3 Suicide 6 Could not	be 290 Place of Injury - At home farm		28f. Location (Str	eet and Number or Ru	ral Route Number,	
Division of Vital Records,	after Dire	Certification;	4 Homicide determine	building, etc. (Specify)		City or Town	State)		
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical C		Physician: To the best of my knowledge, de aminer: On the basis of examination and/or and manner stated.					
	thin 2 the othe	Med	29b. Signature and title of certifier	and marrier stated.	29c. License number	29	d. Date signed (Monti	n, Day, Year)	
	To With		Not .	- Q(M)	OOME	M	ARCH 1,2004		
	7/1		300 Dame and address of person wh	no completed cause of death (Item 23a) (Typ	ne Print)				
	,	-	A A A		111 Penn Street, Balt	imone. Marv	land 21201		
	* St	ate	31. Date filed (Month, Day, Year)	32 Registrar's Signature	Sports				
	Regist		MAR 0 3 20	104 Sucra 19	ppman				

Registrar DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Ma	aryland / Dep <i>Ce</i>	artme e <i>rtifica</i>	ent of H	ealth and M Death	lental Hy	giene 2	004	08784	
			1. Decedent's Name (First, Middle, L.	ast)	-	_			2. Date of De	aath	Vaar	3. Time of Death	
	Physici /Medic		James Richa:	rd Sullivan	ı				March	1, 20	Year 04	10:30 a M	
	Examin		4a. Facility Name (If not institution, gi	ve street and number)		4b. Ci	ty, Town, or	Location of Death		4c. County of Deeth			
			419 Burnt Mills	Avenue				Spring		Mo	ntgom		
	Funeral			Sex 7. Age 1⊈M 2□F	e (In yrs. last birthda	/) If Uno	der 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D	ay, Year)	9. Birth	plece (State or Foreign untry)	
	Director		579-48-1030	IQM ZLIF	71 Yrs.				Sept. 2	21, 1932	- 1	hington, DC	
	pue *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location						10d. Inside City Limits	
	laho	5			0.13							1 ☐ Yes 2 ☑ No	
	28a-	ect	Maryland Montgo	mery	Silve		ring Zip Code			10g. Citizen	of What Cou	untry?	
	with Sa or	0		A						,	TTC A	•	
	ns 23	era	419 Burnt Mills 11. Marital Status	12. Was Decedent I	Ever in U.S. 13	. Was De	20901 cedent of H	spanic Origin? (Sp	ecify Yes or N	o- 14. F	USA Race - Amer		
10	r Her	F	1 ☐ Never Married 2 ☑ Married	Armed Forces? 1 ☑ Yes 2 ☐ N If Yes, Give	ło ·			n, Mexican, Puerto	Rican, etc.)		Black, White		
03	al', o	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	L957-59	1 ∐ Yes	2 ∏ No	Specify:		Spe	ecify: Wh1	te	
21215-0036	72 hours after death with the Maryland natural', or items 23a or 28a-f show Jisal Examinet musi be undified at	Completed by Funeral Director	15. Decedent's 8 (Specify only highest g	ducation	(Giv	e kind of	sual Occupa	turing most of work	ina	16b. Kind of	f Business/I	ndustry	
21	within ene.	nple	Elementary/Secondary (0-12)	College (1-4or 5	life	DO NO	use retired						
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Maryland	be fill d oth	Be	17. Father's Name (First, Middle, Las	t)				18. Mother's Nam					
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Jar	2 sh and 1s m		19a. Informant's Name/Relationship					and Number or Rur					
	l and lealth im 27		Joan E. Sullivan 20a, Method of Disposition	/ Wife	4] 20b. Place of Dis	9 Bu	rnt M		ue, Si	Lver Sp 20c. Locatio	ring.	MD 20901	
Baltimore,	Pages nent of H int: If its		1 ⊠Burial 2 ☐ Cremation 3		cemetery, cr	ematory o	or other plac	Mar	ch 4,				
ţ			* 4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice		St. John			ss of Facility	004	Silv	er Spr	ing, MD	
Ba	permit. Departr Importe any inju		> John E.	Yarku	F 5	ranc:	ls J. nivers	Collins	. W. S	ilver	Inc. Spring	, MD 20901	
			23a. Part1. Enter the disease, or con shock, or heart failure. List ont	plications that caused y one cause on each lin	the death. Do not e	nter the m	ode of dyin	g, such as cardiac	or respiratory a	arrest,		Approximate Interval Between	
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	/Medical Examiner		resulting in death)	W	a consequence of):							5 years	
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	pe sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to for as	a consequence of).								
	and and II-tran	xan	that initiated events resulting in death) Last	c Due to (or as	a consequence of):								
8760,	cate be executed physician and the burial-transit	a											
687	phys phys s the	dical		d									
	that the death certificed by the attending godelached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome						23d.	Date of deliv	verv	
Box	eath atter	clar	in the past 12 months?	1□Live birth 4□Pregnant at		□Ectopic □ Other	pregnancy (specify)	···-		1	Month	Day Year	
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0	ires that signed b	by PI	Part II. Other significant conditions	contributing to death b	ut not resulting in the	underlyin	g cause give	en in Part I.	23e. Did	tobacco use c	ontribute to	the cause of death?	
rds	requires een sign nould be	pa p							1 🗆	Yes 2X No	3 ☐ Pro	bably 4 Unknown	
Records,	> 0 10	Completed							24a. Was		b. Were aut	opsy findings available	
R	0 4 0	E O			_				auto perf	ormed?	death?	ompletion of cause of	
Vital	sician: Th certificate rector, pag	a	25. Was case referred to medical					26. Place of Deat					
1	S 5	To B	examiner? 1 Tes 2 No	Hospital:	nt 2 🗆 ER/Outpati	ent 3	DOA Oth	er: 4 Nursing Ho	me 5 ⊠ Res	idence 6 🗆 0	Other (Spec	ify)	
n of	ng Ph ter th neral		27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Inju (Month, Da	ry 28b. Time y Year) Injury		28c. Injun World	at k?	28d. Describe	how injury occ	curred		
Si	Attending r death.	atic	2 Accident investigeti			М	1 🗆	Yes 2 □ No					
Division	or Att ter de Irset	Certification:	3 Suicide 6 Could not 4 Homicide determine		ury - At home, farm, : c. <i>(Specify)</i>	street, fac	tory, office		28f. Location City or To	(Street and Nu own, State)	mber or Rui	ral Route Number,	
0	urs af	S		1									
	To the Hospital or Attending is within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	29a. Certifier 1 ☑ Certifying F (Check only one) 2 ☐ Medical Ext	Physician: To the best aminer: On the basis of and manner sta	examination and/or	ath occurr investigat	ed at the tin ion, in my o	ne, date and place, pinion, death occur	and due to the red at the time	cause(s) and , date and plac	manner as e, and due	stated. to the cause(s)	
	To the To the Comp	ž	29b. Signature and title of certifier	. 1			29c. Licens	number		29d. Date sig	ned (Month	, Day, Year)	
	1241		find N	Junel	Pmo		d35	996		March	3, 2	004	
	,		30. Name and address of person wh	completed cause of d	eath (Item 23a) (Typ	e, Print)							
_			Linda M. Burrel	1 M.D. 27	30 Univers	sity	Blvd.	#400, Wh	eaton,	MD 209	02		
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) MAR 0 4 2	32. Registr	ar's Signature		raks						

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			For State Registrar	0	State of	f Marylar	nd / Depa	artmen rtificate	t of He	alth a eath	nd Me	ental Hy	giene,	200	L,	087	185
	Physici		1. Decedent's Neme (F NICKI W. SI		st)						1	2. Date of De Month OZ		Yee 200	er)4	3. Time of 7:00	
):-	/Medic Examin		4e. Fecility Name (If not				l Rd.		Town, or L				4c.	County of D	eath		
Z.	Funeral Director		5. Social Security Numb 090-14-451	2 1	ex □M 2∏xF	7. Age (In yrs. 82	. last birthday) Yrs.	If Under Months		Hours	Min.	3. Date of Bir (Month, Da 12 - 6	th y, Year) - 19	9. 8	Birthpla Country	ce (Stete o	r Foreign
	death with the Maryland ms 23s or 28s-f show final be rediffed at	tor		cedent b. County MONTGOM	ERY		ity, Town or Lo		}						t. Inside Ci 1. Yes		
	3s or 28s	i Director	10e. Street and Number 3112 GRACE		OAD #50	19								0g. Citizen of What Country? UNITED STATES			
036	be filed within 72 hours after death with the Marylan Hygione. d other than "natural," or items 23a or 28a-f show svent, Ite Medical Examinar must be multiplial.	Completed by Funeral	11. Marital Status 1 Never Married 3 X Widowed 4	_	Armed Fo	2. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes 2 No Specify:				in? (Spec Puerto R	ify Yes or No ican, etc.)		Black, W	hite, et	nerican Indian,		
21215-0036	filed within 72 hours after Hygiene. ither than "natural, or ite int, the Medical Exaction			. Decedent's Econly highest gra		(1-4or 5+) life. DO NOT use retired)							d of Busine		stry		
Maryland 2	permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygies Important: If Itsm 27 Is marked other ti sny injury op other traumatic svent, II.	To Be Co	17. Father's Name (First, Middle, Last) DAVID WESTON SALLY							's Name (e (First, Middle, Meiden Sumame) KEMPKE						
		•	19a. Informant's Name RALPH H.						Address (Street and Number or Rural Route Numb WOODHAVEN BLVD。BETHESD								
Baltimore,			20a. Method of Disposi 1 ☐ Burial 2 X C 1 ☐ Donation 5 ☐	remation 3 [coln	fory or other place)					Bladensburg, MD					
Ball	permit Depart Import sny in		21. Signature of Funera	MO	~70	Q		1180	0 New	v Ham	pshi	re Ave	. Si				2090
	Pnysician /Medical Examiner		23a. Part1. Enter the d shock, or heart fa Immediate Cause (Find disease or condition resulting in death)	illure. List only	a.	METASTA (or as a consec	ATIC CA			such as c	ardiac or	respiratory a	rest,		W	opproximate nterval Bets Onset and E EEKS	veen Death
8760,	ate be executed hysicien and the burial-transit	lical Examiner	Sequentially list conditi if any, leading to imme- cause. Enter Underlyin Cause (Disease or inju- that intitated events resulting in death) Last	ions, idiate	b. LUNG CANCER Due to (or as a consequence of): c. Due to (or as a consequence of): d.									MONT	HS		
O. Box 68	he death certificat r the attending phy ched for use as th	Physician/Med	IF FEMALE: 23b. Was decedent prein the past 12ynor 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	nths?	tcome of pregn birth 2 Feti nant at time of c own	Fetal death 3 Ectopic pregnancy						23d. Date of delivery Month Day				'ear	
rds, P.	w requires that the de been signed by the s should be detached to	by	Part II. Other significan	nt conditions o	ontributing to d	eath but not res	sulting in the u	nderlying c	ause given	in Part I.			obacco us	e contribute		cause of d	
al Records,	The la ate has page 2	Completed										24a. Was autop perfo 1 Yes		death	to comp	iletion of ca	available ause of
ion of Vital	Attending Physician: If death. sctor: After this certific by the funeral director.	ation; To Be	25. Was case referred examiner? 1 ☐ Yes 2 X No 27. Manner of Death 1 X Natural 2 ☐ Accident 5	to medical Dending investigation	28a. Date (Mon	Inpatient 2 Cof Injury	ER/Outpatien 28b. Time of Injury		A Other: 8c. Injury a Work?	4 □ Nurs	sing Home	Check only of a Second of the Control of the Contro	dence 6		Tios pecify)	cice Casey	Hous
Division	To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by th	Certification;	4 Homicide	Could not be determined	build	of Injury - At h ing, etc. (Speci	(fy)					of, Location (S City or Tox	vn, State)				ber,
	the Hosp hin 24 ho the Fune npletely f	Medical	one)	Certifying Ph Medical Exam	niner: On the b	e best of my knows says of examination of examination of examination of the stated.	owledge, death ation and/or inv	vestigation,	in my opin	ion, deatr	place, an	at the time,	date and I	place, and d	ue to th	ne cause(s)	
•		-	29b. Signature and title	or certifier	Li	bie	MD	1	09470					signed (Mo uary			
			30. Name and address Eugene P.	Libre,	MD	10400	Connect	Print) icut	Avenu	ıe, K	ensi	ngton,	MD 2	20895			
8	Sta Registr		31. Date filed (Month, I	R 0 4 2	32. F	legistrar's Sign		Sp	zeks	/							

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State of Maryland / Department of Health and Mental Hygienes 08786 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** SMITH GILBERT 29th 2004 TEBRUARY /Medical 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deet Examiner Baltimore Johns Hopkins Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Jan. 17 9. Birthplace (State or Foreign **Funeral** 1930 Yrs Marvland 74 Director 218 24 3519 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show item 27 is marked other than "natural", or itams 23a or 28a-f show other trsumatic event, the Medical Event an inner the inclined at Silver Spring 1 Yes 2 No Director Montgomery Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20905 15921 Attleboro Road United States Funerai death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No White Specify: δ Specify. 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Automotive 0 Mechanic 12 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumame) Be Department of Health and Mental important: If item 27 is marked o eny injury or other treumatic evenues. Pages 1 and 2 should be R. Rabbitt Janet 2 Newton Homer Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 15921 Attleboro Road, Silver Spring, Md. 20905 Margaret J. Smith / Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Surial 2 ☐ Cremation 3 ☐ Removal from State St. Johns Cemetery 3/5/04 Forest Glen, Md. * 4 ☐ Donation 5 ☐ Other (Specify) permit. 21. Signature of Funeral Service Licenses ²² Name and Address of Facility Muriel H. Barber Funeral Home write - Banke 20882 P. O. Box 5038, Laytonsville, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PANCREATITIS **Physician** 52 DAYS /Medical Due to (or as a consequence of): **Examiner** PANCREATITIS NECROTZZING DAYS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed physician and the burial-transit ORGAN FAILURE MULTI- SYSTEM Due to (or as a consequence of): Box 68760, Physician/Medical use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetel death 3 Ectopic pregnancy for in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. the (detached 9 Unknown ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, \$ 2 No 1 🗌 Yes 3 Probably 4 Unknown page 2 should Completed been 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No certificate has Division of Vital Yes 2 🗆 No funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? ? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 X Inpatient ٩ 1 Tyes 2 ER/Outpatient 3 DQA 27. Manner of eath
1 Natural
2 Accident 28a. Date of Injury (Month, Day 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After t or Attending 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funstsl Director: A investigation the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Chack only one) 29b. Signature and the of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-000 FEBRUARY 29th 2004 8 30. Nam rouse bress of person who completed cause of death (Item 23a) (Type, Print) WOLFE STREET BALTIMORE, MD 21289-9106 YAMADA NOBUHISA 600 NORTH 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 03 2004 south Registrar

State of Maryland / Department of Health and Mental Hygien 2004 08787 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** FEBRUARY 1531 ROWALO 2004 7. SLUGER /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner MONTOOMETY SUBBREAU HOSBITAL | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Sept. 21,1962 | Pennsylvania BET HEXDA 6. Sex 1 M 2 □ F Birthplece (Stete or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 41 Director 213-90-8749 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County MOU d 2 should be filed within 72 hours after death with the Maryla th and Mental Hygiene. ?? It marked other than "natural", or Itema 23a or 28a-1 ahov froumatic avent, It is Medical Earth and Itematic avent. 1 ☐ Yes 2X No Directo Maryland | Montgomery Germantown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20874 12501 Willow Spring Circle United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White ş 3 ☐ Widowed 4 Z Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Salesman Auto Parts 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Anthony Sluger, Sr. Beverly Ann Richter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Beverly Ann Sluger / Mother 12501 Willow Spring Circle Germantown, MD 20874 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of Hi
Important: if Ites
any injury or ott March 2, 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Parklawn Memorial Park * 4 □ Donation 5 □ Other (Specify) 2004 Rockville, Maryland 22. Name and Address of Facility DeVol Funeral Home Funeral Service Dicensel 21. Signatu 10 E. Deer Park Dr. Gaithersburg, MD Approximate Interval Between Onset and Death Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final SEPSID **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) ow 12/25/2003) Examiner AUTOACCIDENT Samentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-tran Due to (or as a consequence of) Box 68760. attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No ō Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. detached 9 Unknown been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, HEPATIC ENCOLUALOPATHY, ALGORNIA HEND INTURY 2No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 s autopsy certificate 1 Yes 2 No of Vital 25. Was case referred to medical director Be 26. Place of Death (Check only one) examiner? 1 X Yes 2 ☐ No Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After TILLO C DICEO A RAY UNDER NEW LESS Location (Street and Number or Rural Route Number, City or Town, State) Division Injury 5 Pending 1 Natural 21600 1 🗌 Yes death. investigation 12003 2 Accident 17 the To the Hospital or Attenwithin 24 hours after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide WITELIA DILLE, ROCALLUE, MO 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 1015234 FEBRUARY 27, 2004 (DNG) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PIKE, Pouriue, MO 20252 CALL I MARGOLL , NO. 11125 Pockville 31. Date filed (Month, Day, Year) MAR 0 1 32. Registrar's Signature State 2004 Registrar

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onald

J. Sluger

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State of Maryland / Department of Health and Mental Hygiener 08788 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** February 28, Roy Edmond Singleton 2004 6:31 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Takoma Park Washington Adventist Hospital Montgomery Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F Days Director Aug 23, 1927 Washington, DC 577**–**32**–**7863 76 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic avent, the Medical Examinant must be notified at 1 XYes 2 No Director Maryland Prince Georges Beltsville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code deeth v 3912 Howard Rd 20705 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 1955— If Yes, Give Year or Dates: 1985 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Inference if item 27 is marked other than "natural", or itemportent: if item 27 is marked other than "natural", or item any injury or other traumatic avent, I'm Medical Evarthing once. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ No Specify: Specify: 3 Widowed 4 Divorced 1985 White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 3 Contract Specialist Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Carey B. Singleton Cecilia Ackroyd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3912 Howard Rd, Beltsville, MD 20705 Charlotte M._Singleton/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State ¹ 4 □ Donation 5 □ Other (Specify) Gate of Heaven Cem Mar 3, 2004 Silver Spring, MD 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityHines-Rinaldi Funeral Home lersen 11800 New Hampshire Ave, Silver Spring, MD 20904 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner signed by the attending physicien and the detached for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9□ Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in 23e. Did tobacco use contribute to the cause of death? Be Completed by page 2 should be 4 Dunknown 1 ☐ Yes 2 ☐ No 3 Probably been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe or Attending Physician: ector, 25. Was case referred to dical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ Mo 1 Impatient Certification; To 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 ⊟Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t Location (Street and Number or Rural Route Number, City or Town, State) To the Hospitel or At within 24 hours after of To the Funerel Direct 4 - Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License num 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kango Kango Nasreen 31. Date filed (Month, Day, Year) MAR 0 4 20 7610 Ave, # 205 32. Registrar's Signature State 2004 Registra

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month FERWAR **Physician** SHIRVAN 1756 SEYMOUR /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SHADY GLOVE ADUBUTET HOSPITAL ROCKULUS MONTGOMEN If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sax 7. Age (In vrs. last birthday) **Funeral** 1MM 2□F Months TUNE 27, 128-16-3540 1925 NEW YORK Director 78 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location or 28a-f show the Medical Examiner must be notified at 1 XYes 2 No Director NEW YORK NASSAU OLD BETHPAGE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11804 U.S.A. or Iteme 23a 28 EAST PARK DRIVE Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status hours after 1 ☐ Never Married 2 X Marned 1 XYes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: WWII 1 ☐ Yes 2 🕅 No Specify: Specify: WHITE þ 3 Widowed 4 Divorced natural', Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) U.S. GOVERNMENT 12 POSTAL WORKER other permil. Peges 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury goother treumatic event gines. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JOSPEH SHIRVAN LENA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 28 EAST PARK DRIVE, OLD BETHPAGE, NY 11804 DOROTHEA E. SHIRVAN/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) MT. CARMEL CEMETERY 13/2/2004 GLENDALE, NEW YORK 22. Name and Address of Facility
FDWARD SAGEL FUNERAL DIRECTION,
4091 ROCKVILLE PIKE, ROCKVILLE, 21. Signature of Funeral Service Sonald 23a. Part1. Enter the disease, or complications that caused the deth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ATHEROSCIENOTIC CARDIDVASCULAR DISEASE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760. attending physicien Physician/Medical the 38 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? Day Year Month 4 Pregnant at time of death 5 Other (specify) detached ☐Yes 2☐No Ö the 9 Unknown 9 Unknown ģ σ, Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed 23e. Did tobacco use contribute to the cause of death? Records, þ å DOWN STAIRS FINAULE (D) ELEON 1 Yes 2 No 3 Probably 4 Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an The law has page 2 autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes Division of Vital 25. Was case referred to medical examiner?
Yes 2 \(\text{No} \) No 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: After the Hospitel or Attending hin 24 hours after death. the Funerel Director: After 5 Pending 1 Natural FEU DOWN FLITE OF STALL 2/28/04 2 XNo investigation W1600 1 Tyes 2 Accident the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ON OUT THE HOME 28f. Location (Street and Number or Rural Route Number, City or Town, State) | 7 81 | WALES | HILL | 4 Homicide HOME GERMANTOWN WO within 24 hours a To the Funerel C 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal (Check, only Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 2 015236 FEBRUARY La, 2004 N 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1/125 GOCKVILLE PIKT, OLOCKVILLE. MO 20852 OME) MARGOLIS, 6-0 CARL I 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 02 2004 March and ackse Registrar

State of Maryland / Department of Health and Mental Hygiene

			State of Ivid	aryland / De	Sertificate			vientai myt F	leg. No 20	04	08	790
н	Physici	an	Decedent's Name (First, Middle, Last)	-				2. Date of Dee Month	th Dey	Year	3. Time o	of Death
-4	/Medi		David Settles					Februar	y 29,	2004	6:11	AM
_ac.	Examir	ner	4e Fecility Name (If not institution, give street end number)				4b. City, Town, or L		4c. Count	y of Deeth		
			Washington Adventist Hosp 5. Social Security Number 6. Sex 7. Ag	ital e (In yrs. lest birthi	day) If Under		Takoma Pa			tgome		-
	Funeral Director		579-07-5023 Usual Residence of Decedent	89 Yr	Months	Days	Hours Min.	8. Date of Birth (Month, Day Aug. 30	, 1914	South	olace (State ntry) n Caro	or Foreign lina
	arylend show	L	10a. State 10b. County	10c. City, Town o	or Location					1	10d. Inside C	
	Sa-f	20	Maryland Montgomery	Burtons								2 □ No
	with the	F	10e. Street end Number		10f. Zip (1	l 0g. Citizen of	Whet Cour	ntry?	
	eath 23	erai	14812 McKnew Road 11. Maritel Status 12. Was Decedent I	Ever in II S		2086			United	State		
21215-0020	filed within 72 hours efter death with tha Marylend Hygiane. ther than "natural", or hems 23a or 28a-f show ant, the Medical Examiner must be northed at	Completed by Funeral Director	1 Never Married 2 Married 1 Never Married 2 Married 1 Yes 2 0 N H Yes, Give Year or Dates:	lo	If Yes, special		ispanic Origin? (Sp in, Mexican, Puerti Specify:	Rican, etc.)	Specil	ick, White,	etc.	
5-0	72 ho	ted	15. Decedent's Education (Specify only highest grade completed)	16a. D	ecedeni's Usual	l Occupa	ation	kina	16b. Kind of B	lusiness/In	dustry	
121	ithin ithin	nple	Elementary/Secondary (0-12) College (1-4or 5	+)		e retired	during most of world	King	0.1			
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Maryland	2 should be filed within end Mantal Hygiane. is marked other than aumatic event, the Manatic event, the Mana	Be	17. Fether's Name (First, Middle, Last)				18. Mother's Nam	•	Maiden Sumai	ne)		
Ž	d Mai d Mai marks martic	7	Peter Settles	106.4	Anilina Autorea	/Otra a4 :	Gustan		0/h	00.4. 70	0.71	
Ma	d2s then 7 is r trau		19a. Informant's Name/Relationship (Type, Print) Shirlee Franklin (Daught				and Number or Ru					
-	ss 1 and 2 should be filed within of Haaith end Mantal Hygiane. Item 27 is marked other than other traumatic event, the Ms		20a. Method of Disposition		isposition (Name crematory or oth		Road, Bu	1	LIE, MD 20c. Location			
Baltimore,	ment of the state		XXBurial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)		nd Nati	ona]	L	3/6/04	Laurel	, Mar	yland	
Bal	permit. Pages 1 Department of Hi important: If iten any injury or oth		21. Signature of Funeral Service Licensee		22. Name and 7400 G	a Address	ss of Facility McG gia Ave.	uire Fur N.W., Wa	neral S shingt	ervic on, D	e .C.	20012
			23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin	the death. Do not	enter the mode	of dying	g, such es cardiac	or respiratory arm	est,		Approximat Interval Bet	te tween
1	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	girad	org	f	Failu	re		:	Onset end	Death
	uted 1 ensit	Physician/Medical Examiner	e b. Hy	20V01	A M	c	Sh	200110				
Š,	rificete be executed ng physician end es the buriel-trensit	Exa	Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initieted events	Oue to (or as a cor	rsequence on:	X.	meur	220011	7	į		
68760,	ifficete b g physic es the b	edica	that initieted events resulting in death) Last	Due to (or as a con	sequence of):		•	, 5.7,0				
Вох	2 2 0	2	d									
	death ce e ettendi ed for use	icla	Part II. Other eignificant conditions contributing to death but	t not resulting in th	ne underlying car	use dive	an in Part I	23h Did to	bacco use co	ntribute to	the cause	of death?
P.0	uiras thet tha des signed by the e	Phys	Tarm Street Significant Conditions Continuously to death but	t not resulting in the	e underlying car	use give	on in Farti.		s 2 No	3 Prob		Unknown
Records,	requiras thet tha reen signed by th hould be detache	d by						24a. Was ar		24b. We	ere autopsy f	findings
eco	aw 2 s	Completed						perform	ned?	con	ailable prior t mpletion of c death?	ause
_	The ate h page	Соп						1 7 Ye	5 20 110	10	Yes 2	No
Vital	ician: The certificate rector, pag	Be	25. Was case referred to medical examiner?				26. Place of Deat	h (Check only on	θ)			
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LC.	After fune	ion	27. Manner of ath 1 Natural 5 Pending (Month, Dey	y 28b. Tim Year) Inju	e of 280 ry Mr	C. Injury Work	rat t? Yes 2 □ No	28d. Describe ho	w injury occur	red		
Division	Attending I er death. ector: After by the fune	Certification:	a \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	ry - At home, farm,			765 Z NO	28f. Location (Str City or Town		er or Rura	l Route Num	nber,
	To the Heepital or Attending Physician: within 24 hours after deals. To the Funeral Director: After this certific completely filled in by the funeral director,		29a. Certifier 12 CertifyIng Physician: To the best of		eath occurred at	t the tim	e date and place				-10-	
	the Hou in 24 h the Fun ipletely	edical	(Check only one) 2 Medical Examiner: On the basis of end manner state	examination and/o	r investigation, in	in my op	inion, death occur	red et the time, da	ate and place,	and due to	the cause(s	;)
D		Σ	29b. Signature and title of certifier	Sil	29c. 1	License 2	number +54	7/ 25	Od. Date signe	Month, E	Day, Year)	À
- -	Image: section of the content of the		30. Name and address of person who completed cause of de	ath (Item 23a) (Ty	pe Print)	. J) in	Shung	Hen	AU	very	h. St.
	Sta Hegistra	1000	31. Date filed (Month, Day, Year) MAR 0 3 2004 32. Registral	r's Signature	Spo	uks		/		1	707	fol

			1 For State	State of Ma	ryland	d / Depa	irtment <i>tificate</i>	of He	alth and I	Mental Hy		004	08791
		65	Registrar 1. Decedent's Name (First, Middle, Last,)			liicate	9 01 0	caur	2. Date of D			3. Time of Death
	Physici: Medic/		GLADYS F	SEAY						MARCH	Day /	Year 2004	3:14PM
	Examin		4a. Facility Name (If not institution, give		RE		-		ocation of Death	1	4c. Co	ounty of Death	1
	uneral		5. Social Security Number 6. Sec			ast birthday)	If Under	1 Year	NONE If Under 24 Hrs.	8. Date of B	rth	9. Birth	oplace (State or Foreign untry)
	rector		213-20-8847	M 250 F	34	Yrs.	Months	Days	Hours Min.	July	17,19		aryland
and	M TI		Usuel Residence of Decedent 10a. State 10b. County	Т	10c. City	, Town or Lo	cation						10d. Inside City Limits
Магу	ef show	tor	MD Howard			Colum	bia						XXYes 2 □ No
ith the	or 28e-f	Oirec	10e. Street and Number	_	_		10f. Zip				10g. Citizer	n of What Cou	untry?
w the	e 23e	erail	5914 Steven	FOREST F			Vac Decede		.046	necify Ves or N	0- 14	U.S.	
offer de	or Iteme	Fun	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 🔀No			_		manic Origin? (Si Mexican, Puerti	Rican, etc.)		Black, White	, etc.
d 21215-0036 filed within 72 hours after deeth with the Maryland Hydiene.	- 3	Completed by Funeral Director	3 ☐ Widowed 4 💆 Divorced	If Yes, Give Year or Dates:			☐ Yes 2		Specify:				lack —————
15-0		ojete	15. Decedent's Edu (Specify only highest grad	e completed)		16a. Deced (Give I life. L	lent's Usual kind of worl OO NOT use	k done dui	on ring most of wor	king	16b. Kind	of Business/Ir	ndustry
212 d with	other then vent, the Ma	Comp	Elementary/Secondary (0-12) 7th	College (1-4or 5+	+)	Nu	rsin	g As	sistar	ıt	H	EALTH	Dept.
Ē 9 m		Be	17. Father's Name (First, Middle, Last)					1	8. Mother's Nam			mame)	
Maryland nd 2 should be file tith and Mental Hy	if Item 27 is marked or other traumatic e	으	John T. Johns 19a. Informant's Name/Relationship (Ty		_	19b. Mailin	o Address	(Street and	Mary d Number or Ru	J. Wi		own State Zi	in Code)
Magnet 2 salth ar	27 is or trau		Eric M. Seay (-		Ave.,				
Baltimore, Permit. Peges 1 ar Department of Hea	r othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F	lemoval from State		ace of Dispos metery, crem	sition (Nam natory or oth	e of her place)		Date	20c. Locat	tion - City or T	own, State
timor	Important: If Ite any injury or of once.	7/1	*4 □ Donation 5 □ Other (Specify) 21. Signature □ □ □ □ Service Lio n		Co.	lumbi				/04			le, MD
Balti permit. Departe	any ir		Kanga K,	Hadu	de	U 2	46 N	. Wa	sh. St	., Roc	kvil		OME, P.A. D 20850
Pmy	sician	5 0	23a. Part 1. Enter the disease, or compl shock, or hear bailure. List only or Immediate Cause (Final disease or condition	idations that caused to be caused to be cause on each line of the cause of the caused to be caus		. Do not ente	er the mode	of dying,	such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
/M	edical miner		resulting in death)	Due to (or as a		ence of):							3 1 44 5
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8760, cate be executed	physicien and the burial-transit	Exa	resulting in death) Last	Due to (or as a	conseque	ence of):							
		dicai		J									
Box 6	attending for use as	n/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome o			F-1i				23d	. Date of deliv	өгу
LADYS, Records, P.O. Box E	the atte	by Physician/M	in the past 12 months? 1 □ Yes 2 MNo 9 □ Unknown	4 Pregnant at ti			Ectopic pre Other (spe					Month	Day Year
, P	signed by the d be detached	y Ph	Part II. Other significant conditions cor		t not resul	ting in the un	derlying ca	use given	in Part I.	23e. Did 1	obacco use	contribute to 1	he cause of death?
rds	been sign	ed b	HYPERTENSION							1 🗆	Yes 2XN	lo 3 ☐ Prof	bably 4 Unknown
らんれつイム Vital Records,	has been ge 2 shoult	Completed	ALZHIMENIS	DE MEN	71A	,				24a. Was	DSV	4b. Were auto	opsy findings available ompletion of cause of
) L L	r, page									1 Yes	2 No	death?	2□ No
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n of	fer the		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day		28b. Time of Injury		c. Injury at Work?		28d. Describe	· · · · · · · · · · · · · · · · · · ·		<i>y</i> /
SEAY Division of to Attending Phylatter death.	tor: A	catic	2 Accident investigation 3 Suicide 6 Could not be			22 12	М	1 🗌 Ye:	s 2□No	38f Logation (Strant and Al	lumbar or Dur	-I Pouto Alumbas
Divi	el Direc led in by	Certification:	4 Homicide determined	28e. Place of Injur building, etc.	(Specify)	ne, iaim, stre	et, factory,	опісе		City or To		umber of Aura	al Route Number,
ne Hospi 7 24 houn	To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical	29a. Certifier (Check only one) 1 Certifying Physical Examination (Check only one)	sician: To the best of ner: On the basis of e and manner state	examinatio	rledge, death on and/or inv	occurred a estigation, i	t the time, in my opin	date and place, ion, death occur	and due to the red at the time,	cause(s) and date and pla	d manner as s ice, and due to	stated. to the cause(s)
Tott	COM	ž	29b. Signature and title of certifier	`				License n	4 .	and the state of t		igned (Month,	
	5		IVI	<i>)</i> ,				67	66		VIHIC	H1, 2	2004
			30. Name and address of person who co	MD. 900	CA7	ZSa) (Type, F	AUE.	BA	KT (MOI	ré Mo	D. 21.	229	
	Sta Registra		31. Date filed (Month, Day, Year) MAR 0 4 200	32. Registrar	s Signatu معمر	Le G	Spa	KN					

State of Maryland / Department of Health and Mental Hygiene 004 08792 For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) March 3, 2004 **Physician** Gill Von Schmittou 8:10 p M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Manor Care, Chevy Chase Chevy Chase Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Nov. | 1900 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Tennessee M 2□ F 577.03.7790 103 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location or 28a-f show the Medical Examiner must be notified at MD Chevy Chase Montgomery 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20815 8700 Jones Mill Road U.S.A. or flems 23s Pages 1 and 2 should be filed within 72 hours after death 1 nent of Health and Mental Hygiene.
Int: If Item 27 Is marked other than "natural", or Items 23.
Ity or other treumatic event, the Medical Examination in the Install. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No White Baltimore, Maryland 21215-0036 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Clerical D.C. Transit 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Thomas Schmittou Mary Reynolds ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jane Kippley/Daughter 3154 Patterson Street, NW Washington DC 20015 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Mathod of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: if Ite
any injury or oth 1 Burial 2 □ Cremation 3 □ Removal from State Gate of Heaven Cem. March 9,2004 Silver Spring, MD ^ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Joseph Gawler's Sons, 21. Signature of Ineral/Service License e 5130 Wisconsin Avenue NW WDC 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Pnysician Atherosclerotic Cardiovascular Disease resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate ease. Into Underland Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Completed by Physician/Medical Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) signed by the a t be detached f 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Deafness 23e. Did tobacco use contribute to the cause of death? 4XXUnknown 3 Probably 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Blindness page 2 autopsy performed? Yes 21 No Hypothyroidism and Anemia certificate 1 Yes To the Hospitel or Attending Physician: Mithin 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 27. Magner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 🔀 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier D43254 March 4, 2004 auser 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lauren E. Cosgrove, M.D. 6111 Executive Blvd. Rockville, MD 20852 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 05

Registrar

State of Maryland / Department of Health and Mental Hygien 2004 1 - For State Registrar 08793 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Mildred Davies Schmick February 21 2004 /Medical 4:45 A N 4a. Fecility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 8811 Colesville Road #301 Silver Spring Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) August 22 1916 **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🔽 F 87 Director 577-01-1867 Yrs Virginia Usual Residence of Decedent with the Maryland orent: If tiem 27 is marked other than "natural; or liems 23a or 28a-1 show injury or other traumatic event, the Medical Examiner must be notified at 8. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland 1 Tyes 2 □ No Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8811 Colesville Road #301 20901 U.S.A. death Funeral 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2√ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specity þ White 3 Widowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home permit. Pages 1 and 2 should be file Department of Health and Mental Hy, important: If item 27 Is marked other any injury o_L other traum-st-17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frederick D. Davies Jesse Price 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Julie Gingrich - niece 8250 Ashford Blvd., Laurel, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1

Burial 2 □ Cremation 3 □ Removal from State

1 □ Donation 5 □ Other (Specify) Parklawn Mem. Park 2-28-2004 Rockville, Maryland 21. Signal ral Serie 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Av., Silver Spring, MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Multiple Sclerosis years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. attending physician Physiclan/Medical the IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death ō in the past 12 months?

1 Yes 2 XNo 3 Ectopic pregnancy 4☐ Pregnant at time of death Day Year 5 Other (specify) Division of Vital Records, P.O. the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by pg Cerebrovascular Disease Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Hypertension autopsy performed? certificate Valvular Heart Disease 1 Yes 2 XNo Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 Yes 2 XNo Other: 4 Nursing Home 5 MR Residence 6 Other (Specify) Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After 28d. Describe how injury occurred 5 Pending Injury death. investigation 2 Accident 1 ☐ Yes 2 ☐ No hours after death uneral Director: the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral I

completely filled 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D33159 February 25, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8700 Georgia Ave, Ruth Cohan, MD #400, Silver Spring, MD 20910 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 02 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 08796 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** February 28, 2004 6:35 A Helen Glock Scali /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Manor Care Potomac Potomac 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Q 1 Months Days Hours Min. 8. Date of Birth (Month, Day, Ye June 28, Birthplace (State or Foreign Country) 5. Social Security Number Year) 1922 **Funeral** 1 ☐ M 2 🖫 F 81 Pennsylvania 193-18-1883 Yrs Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County permil. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or Items 23s or 28s-f show any joury or other traumatic event. It a Medical Exercitive most be inclined at once. Montgomery 1 ☐ Yes 2 X No Bethesda Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5604 Chesterbrook Road 20816 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White Baltimore, Maryland 21215-0036 Š 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Receptionist WC & AN Miller Company 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Claire McNelis Earl F. Glock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paula Scali/ Daughter 5604 Chesterbrook Rd., Bethesda, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1

Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Mar. 3, 2004 Silver Spring, MD Gate of Heaven Cem. 22. Name and Address of Facility Joseph Gawler's Sons, Inc. 21. Signature of Funeral Service Licensee MO1296 5130 Wisconsin Ave., NW, Washington, DC Mima 20016 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 6 Months **Physician** Stroke /Medical Due to (or as a consequence of): Examiner 10 Years Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner 10 Years the death certificate be executed Diabetes Mellitus the attending physician and Due to (or as a consequence of): burial-1 Division of Vital Records, P.O. Box 68760, Physician/Medical as the IE FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Day Month Year in the past 12 months? 4□Pregnant at time of death 5 Other (specify) ☐ Yes 2 X No 9 Unknown 9 Unknown signed by det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ pe 1 ☐ Yes 2 🔀 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? 2X No 1 ☐ Yes 2 ☐ No certificate 1 Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient Other: 1 ☐ Yes 2X No 2 ER/Outpatient 3 DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 X Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No death. investigation 2 Accident the To the Hospital or Attene within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, larm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Anathan M D0053615 March 2, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Aruna S. Nathan, M.D. 11125 Rockville Pike, #208, Rockville, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 0 4 2004 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar	State of M	aryland / Dep <i>Ce</i>	ertificate of I		Mental Hy	rgienę () () Reg. No.	4 08795
			1. Decedent's Name (First, Middle, L	.ast)				2. Date of D		3. Time of Death
	Physici /Medio		Julia Fra	nces Saffor	rd				ary 27, 20	n u
	Examin		4a. Facility Name (If not institution, g	ive street and number,		4b. City, Town, or	Location of De	ath	4c. County of I	Death
-			Montgomery Gen	eral Hospi	tal	01ne			Montgo	
	Funeral			Sex 7. A	ge (In yrs. last birthda	(y) If Under 1 Year Months Days	If Under 24 H	n. (Month, D	ay, Year)	. Birthplace (State or Foreign Country)
	Director		579-22-2895	TO M ZUAN	94 Yrs.			March	9, 1909 W	ashington, DC
	and *		Usual Residence of Decedent 10a, State 10b, County		10c. City, Town or	Location				10d. fnside City Limits
	Many!	5	Maryland Montg	omoru	C 1 1 170	r Spring				1 ☐ Yes 2 ② No
	28a-	ect	10e, Street and Number	Omery	SIIVE	10f. Zip Code			10g. Citizen of Wha	at Country?
	Se or	0	14400 Homecrest	Drive		20906			TI	JSA
	ms 2:	Funeral Director	11. Marital Status	12. Was Decedent	Ever in U.S. 13	. Was Decedent of H	ispanic Origin?	(Specify Yes or N	o- 14. Race -	American Indian,
က	or Ite	Für	1 Never Married 2 Married	Armed Forces	No	If Yes, specify Cuba 1 ☐ Yes 2 🖾 No		erto Hican, etc.)	1	White, etc. White
03	72 hours alter death with the Maryland natural; or Items 23a or 28a-f ehow deat Examble must be notified at	by	3 ⊠Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		10 165 223140	эрөспу.		Зреспу.	WIIICC
21215-0036	72 hc	Completed	15. Decedent's (Specify only highest of	Education grade completed)	(Gi	edent's Usual Occup	during most of w	vorking	16b. Kind of Busin	ness/Industry
21	of thin	mpi	Elementary/Secondary (0-12)	Coltege (1-4or	5+) life	DO NOT use retired	7)		0 7	1
2	led w lygier her ti	S	17. Father's Name (First, Middle, La	ct)		Homemaker	18 Mother's N	ame (First Middle	Own H	lome
and	ntal H	Be	Edgar Jordan	31)				nne LePr		
2	d Mer nark	70	19a. Informant's Name/Relationship	(Type Print)	19h Ma	iling Address /Street			ber, City or Town, Sta	ate Zin Code)
Maryland	d2s than trau		Suzanne S. Neal						erson, MD	
ō,	1 an Heaf Iem 2		20a. Method of Disposition	-, Baugneer	20b. Place of Dis	position (Name of rematory or other place		Date	20c. Location - Cit	
JO L	ages ant of		1 ☑ Burial 2 ☐ Cremation 3 1 ☑ Burial 2 ☐ Cremation 3		•	coln Cemet	ria	rch 3, 2004	Brentwoo	od, Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural; or items 23s or 28s-f show any nury or other traumatic event, the Medical Experiment and be notified at once.		21. Signatur I Pineral Service Lin	A		22. Name and Addre	ss of Facility			•
B	Per Per Per Per Per Per Per Per Per Per		CobertCA	amse)	Francis J. 500 Univer	Collin	s Funera	l Home Ind S ilver Spr	cine MD 20901
		Г	23a. Part1. Enter the disease, or co shock, or heart failure. List or Immediate Cause (Finat	omplications that cays	d the death. Do not eline.	inter the mode of dyin	ng, such as card	iac or respiratory	arrest,	Approximate Interval Between Onset and Death
1	Physician /Medical		disease or condition resulting in death)	a. Due to for a	s a consequence of):	epsus				_ 2 days
	Examiner			. Due to (or a	3 a consequence (i).	Preun	OLKE			& da
	3	Jer	Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or a	s a consequence of).					1
	cuted nd ransit	Examiner	that initiated events	c		Deme	itia			years
0,	ate be executed hysician and the burial-transit	Ex	resulting in death) Last	Due to (or a	s a consequence of):					
8760	ate b	llcai		d						
œ ×	death certificate e attending phys d tor use as the	Physician/Med	IF FEMALE:	23c. If yes, outcom	e of pregnancy				23d. Date of	of definer
Вох	attend for us	ian	23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fetal death	B Ectopic pregnancy	1		Month	,
o.	that the de ed by the detached	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unknown	at time of dodin					
Q.	requires that the een signed by the	P.	Part II. Other significant condition	s contributing to death	but not resulting in the	underlying cause giv	ren in Part I.	23e. Did	tobacco use contribu	ute to the cause of death?
ds	puires that n signed I	d by	(Mara	trolled	bea-	bolosn	rolliti	10 10]Yes 2□No 3[□ Probably 4 ☑Unknown
OS	> 0 2	lete						24a. Wa	s an 24b. We	re autopsy findings available
Records,	0 - 0	Completed						- auto per 1 ☐ Yes	formed? dea	or to completion of cause of th?] Yes 2 □ No
ital	ician: The certificate ector, pag	4	25. Was case referred to medical				26. Place of D	eath (Check only		
1	lysician: is certific director,	To B	examiner? 1 ☐ Yes 2 No	Hospital: 1 XInpai	tient 2 ER/Outpat	ient 3□ DOA Oth	ier: 4 🗌 Nursing	Home 5□Res	sidence 6 Other	(Specify)
0	ding Phy h. Atter thi tuneral		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of in (Month, D	jury 28b. Time ay Year) 1 fnjur	/ Wor		28d. Describe	how injury occurred	
Sio	Attending Physician: r death. sctor: Atter this certific by the funeral director,	cati	2 Accident investiga 3 Suicide 6 Could no	t bo			Yes 2 □ No	001.1	(0)	2 - 12 - 1 - 1
Division of Vital	or Ati	Certification:	4 Homicide determin	28 e. Place of I	njury - At home, farm, etc. (Specify)	street, factory, office			own, State)	or Rural Route Number,
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely tilled in by the	Sal Ce	29a. Certifier	Physician: To the bes	t of my knowledge, de	ath occurred at the til	me, date and pla	ace, and due to the	e cause(s) and mann	er as stated.
	in 24 in 24 ihe Ft	Medical	one)	caminer: On the basis and manner:				control at the time		
1	To the I	Z	29b. Signatu and title of certifier	-11.	Con	29c. Licens	e number	a	29d. Date signed (/	vioriti, Day, Year)
	21		1 Jones	ences	Ca W	リリン	,066	1	1661	1,200
	-		30. Name and a dress of person w	ho completed cause of	death (Item 23a) (Type	e, Print)	1, 81	VD S.	JO 330	Rocking
	C+	ate	31. Date filed (Month, Day, Year)		trar's Signature	I CANDENANT	A	- 2 211		TINOUNA
	ા Regist		MAR 0 5	2004	were B	Spark	21			

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygien 👂 🕦 👢 08796 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 00266 9:20 A M March 2004 101420 /Medical 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Annapolis 1980 Fairfax Road If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Yeer) July 4, 19 Birtholece (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 1**∑**M 2□F 82 Yrs. Ĩ921 093-14-0307 Rhode Island Director Usuet Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heatth and Mental Hygiene.

ent: If itsm 27 is marked other then "naturs!", or items 23s or 28s-f show ury or other traumatic event, if a Medical Exsinited must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1√2 Yes 2 No Maryland Anne Arundel Annapolis Completed by Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1980 Fairfax Road 21401 U.S.A. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Armed Forces: 1 Mayes 2 □ No If Yes, Give Year or Dates 941-1967 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. White Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Musician U.S. Navy 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumame) Be Richard D. Sowell, Sr. Anastasia L. Bowes ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Lois Sowell/wife 1980 Fairfax Road Annapolis, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or Maryland Veterans Cem. 3/5/2004 Crownsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition **Enysician** SOPHAGENZ Chrowson resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner ng physician and as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetel death Day in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by NERDOWN SYNTEM MEMORNES 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2/D/No Hospital or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After Injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation the within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of perti ところべく MARCH 2 2004 30. Name and ordress of person who completed cause of death (Item 23a) (Type, Print) Dr. Anthony Caputo 139 Old Solomons Island Road Annapolis, MD 21401 31. Date filed (Month, Day, Year) 32. Agistrar's Signature MAR 0 3 2004 Registrar

State of Maryland / Department of Health and Mental Hygien 🤊 በ 👢 08797 For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** P^{M} Michael Nicholas Scarpelli March 2004 6:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Heritage Harbour Health & Rehab. Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 15 M 2 ☐ F 579-03-9246 92 Director June 8, 1911 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits 28a-f show ral', or Itams 23a or 28a-f shov Examiner must be notified at 1√2 Yes 2 □ No Maryland Anne Arundel Annapolis Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 216 Wardour Drive 21401 Funeral U.S.A. death 12. Was Decedent Ever in U.S. Amed Forces?
1 Styles 2 DNo If Yes, Give Year or Dates: 1943–1946 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: À Specify: White 3€ Widowed 4 Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation Give kind of work done during most of working life. DO NOT use retired) is marked other than aumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Marble Mason Masonry 3 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) nt of Health and Mental H
t: If item 27 is marked ott

or other traumatic even Be Joseph Scarpelli Mary Mele 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dolores Patterson/daughter 7 Sherwood Road Annapolis, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department Important: If any injury o Maryland Vets. Cemetery * 4 ☐ Donation 5 ☐ Other (Specify) 3/8/04 Crownsville, MD 22. Name and Address of Facility John M. Taylor Funeral Home Tuneral Service Licenses 21. Signatur 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ardiac **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence off burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, physician Physician/Medical the ası attending IF FEMALE esn 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy ō in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) P.O. 1 Ves 2 No he 9 Unknown 9 Unknown ned by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records. þ sign. 1 Yes 2 No 3 Probably 4 20nknown Completed Deen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 has autopsy certificate 1 ☐ Yes or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Wursing Home 5 Residence 6 Other (Specify) ို 1 Yes 2 No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) uneral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Division 1 Natural 5 Pending investigation after death.

I Director: Af in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide within 24 hours a

To the Funeral C

completely filled i To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical 29b. Signatura d title of certifie 29c. License number 29d. Date signed (Month, Day, Year) address of person who completed cause of death (Item 23a) (Type, Print) VESTEZZI ANNTA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 0 5 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2 ď 8 4 Herndon Emerson Steilkie 8:45a /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Locetion of Death Examiner Talbot 8159 Bozman Rd. Bozman If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth Month, Day, 5-15-1 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** Days Hours 1**⊠**M 2□F 217-10-3659 84 Bozman, MD. Yrs Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Evantiner must be notified at Talbot MD Bozman 1 XYes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21612 USA 8159 Bozman Rd. Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 □ X es 2 □ No If Yes, Give Year or Dates: ₩WII 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status Pages 1 and 2 should be filed within 72 hours atter nent of Health and Mental Hygiene. ent if item 27 is marked other than "natural", or the ury or other traumatic event, the Medical Essistant 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No SpecWhite ል 3 □ Vidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Seafood \$ Building waterman & carpenter 8 years
17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Mary Eva Jones Brooks Bryan Steilkie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10653 Three Bridges Branch RdCordova, MD. Herndon Steilkie, Jr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Importent: If any injury or once. Woodlawn Memorial 3-5-2004 Easton, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility P.O. Box 518, St. Michaels, MD. 21663 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as caldiac or respiratory arrest.

Approximate Interval Between Onset and Death Immediate Cause (Final oncer una **Physician** months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner e0-1 mo Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) certificate has been signed by the a rector, page 2 should be detached to 1 ☐ Yes 2 ☐ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 2 No 1 Yes Hospital or Attending Physicien: 25. Was case referred o medical examiner? director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After thi funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death. • Funeral Director: A investigation 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 \ Homicide 29a. Certifier 1 🔍 certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ical within 24 hor To the Fune completely fi 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) H42587 03/2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Russell Shilling, DO. 555 Cynwood Dr. Easton, Md. 2. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day}2004 **Physician** MARCH 2, 0825 Ам Elizabeth Louise Sipes /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner ALLEGANY CUMBERLAND MEMORIAL HOSPITAL | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | O 5 / 2 3 / 1 9 1 6 5. Social Security Number 9. Birthplace (State or Foreign Country) West Virginia 6 Sex 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🛱 F 216-14-1128 87 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location. 10d. Inside City Limits 28a-f show other traumatic event, the Medical Extrogram quantities at 1 Yes 2 No Director Allegany Cumberland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 135 N. Mechanic Street USA 21502 Itema 23a by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 2 should be filed within 72 hours after of and Mental Hygiene. Black White etc 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify: 3 Widowed 4 Divorced Year or Dates: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Receptionist Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George Washington Allender Verna 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 Is n any injury or other traun V. Patrick Knippenberg /grandson 345 Wood Avenue, Winchester, VA 22601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Cumberland Crematory 03/03/2004 Cumberland, MD ⁴ □ Donation 5 □ Other (Specify) 21. Signatury of Funeral Service Licenses 22. Name and Address of Facility Adams Family Funeral Home, I.A. once. E. 404 Decatur Street, Cumberland, MD 21502 alux 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final 1 Onsar End Regth SEVERE AORTIC STENOSIS Physician resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed burial-transit and Due to (or as a consequence of) attending physician Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy ò in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? pe diabetes mellitus 1 Yes 2 No 3 Probably 4 XUnknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? 1 Yes 2 No or Attanding Physician: rector, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitaf: ۵ 1 ☐ Yes 2 🔀 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural 2 ☐ Accident death. 1 ☐ Yes 2 ☐ No in by the I within 24 hours after deatl To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital filled 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exampler: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. within 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00033280 March 2, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar

ななら

Baltimore, Maryland 21215-0036

Box 68760,

P.O. I

Division of Vital Records,

SUNIL GUPTA, M.D. 625 KENT AVENUE CUMBERLAND, MD 21502 32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene o o l

			1. Decedent's Name (First, Middle, Last)	ertificate of	Death	2. Dete of Deet		3. Time of Death
	Physici /Medio		MARGARET BISHOP LISTER STUBBS			FEB. 2	8, 2004 Year	10:30 AM
	Examir		4e Fecility Neme (If not institution, give street end number)		4b. City, Town, or L	ocation of Death	4c. County of Death	n
			6142 MAIN STREET		QUEENSTO		QUEEN AN	NE
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. lest birthde	y) If Under 1 Yea Months Deys		8. Date of Birth (Month, Day, DEC. 18,	9. Birtt Col. 1925 MAR	nplace (Stete or Foreign untry) YLAND
	pue *		Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location				10d. Inside City Limits
	f sho	ŏ						1X Yes 2□No
	the 188	e c	MD QUEEN ANNE QUEENS 10e. Street end Number	10f. Zip Code		10	og. Citizen of Whet Co	untry?
	ith with the Marylen 23e or 28e-f show ust be notfried at	Funeral Director	6142 MAIN STREET	216	58		USA	,
	me 2	era	11 Maritel Status 12. Wes Decedent Ever in U.S. 13		Hispanic Origin? (Sp ben, Mexican, Puerto	ecity Yes or No-	14. Race - Amer	
חלח	72 hours after death with the Marylend natural', or items 23s or 28e-f show alest Examiner must be notified at	by Fur	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 🛣 No		Rican, etc.)	Specify: WH	e, etc. ITE
5	n 72 hours "natural", edical Exe	ğ	15. Decedent's Education 16a. Dec	cedent's Usual Occu	upetion	rin -	16b. Kind of Business/l	ndustry
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land	ould be fill Mental H arked oth	o Be	17. Father's Neme (First, Middle, Last) BISHOP LISTER		18. Mother's Nam	e (First, Middle, N Y SMITH	faiden Surname)	
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	EVEN		23a. Part1. Enter the disease, or complications that a used the death. Do not e shock, or heart failure. List only one caus on each line.				ILLE, MD 2	Approximate
×	Physician		snock, or near failure. List only one cause on eech line.				1	Interval Between Onset and Death
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	Withi To #	Σ	29b. Signature end title of certifier		se number		d. Date signed (Month,	
			Sandy Jems	D3235	3		March 1, 20	704
			30. Name and eddress of person who completed cause of death (Item 23a) (Type DANIEL JAY KONICK, M.D., 130 LOVE PO	Print) INT ROAD,	STEVENSV	ILLE, MD	21666	
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signeture	-				
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DHMH 16 Rev 6/95

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	Physici	an	Decedent's Name (First, Mid				1					2. Oate of De Month	Da		Yeer	3. Time of Death
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bu			Usual Residence of Decedent 10a, State 10b, Coun	tv		10c Ci	ty, Town or Lo	cation								10d. Inside City Limits
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4	r 28a	Irec	10e. Street and Number					10f. Z	ip Code				10g. C	itizen of V	Vhat Co	untry?
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Hoan	in 24 hou	Medical	one)	al Exan	ysician: To the best on niner: On the basis of and manner sta	examina	owledge, death tion and/or inv	estigatio	on, in my opi	inion, dea	nd place, a ath occurre	nd due to the ad at the time,	cause(s date an) and ma d place, a	nner as ind due	stated. to the cause(s)
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			30. Name and address of person						h:1:-	Dri	O	Inorr P	Mass.	1004	200	222
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death **Physician** TECK 2004 March 7:41P. MARY /Medical 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hebrew Home of Greater Washington Rockville Montgomery If Under 24 Hrs.
Hours Min.
May 1949 1948 If Under 1 Year 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 25€ F 95 New York Yrs. Director 230-22-8064 Usual Residence of Decedent permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Depertment of Health end Mentel Hygiene. Depertment of Health end Mentel Hygiene important: if item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Exteriment must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Rockville 1 ☐ Yes 2 XNo Maryland Montgomery Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number 20852 6121 Montrose Road, #483N. United States Funeral Raca - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2√ No If Yes, Give Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: ξ White 3 ☐ Widowed 4 ☐ Divorcad Completed 16a. Decadent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry College (1-4or 5+) 1-4 Elementary/Secondary (0-12) Real Estate Salesperson 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Silverstein Rose Bronfein Louis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5323 Randolph Road, #4 Rockville, Maryland 20852 Myrna Teck -Daughter 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State riace of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crematory 3/3/2004 Alexandria, Virginia 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Servica Lidense Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) e. ACUTE MYDCARDIAL INFARCTION

Due to (or as a consequence of): Examiner CORDNARY ARTERY DISEASE Physician/Medical Examiner The law requires that the death certificate be executed ettending physician and for use es the burial-transit Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Records, P.O. Box 68760 Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the ceuse of deeth? 1 Yes 3 ☐ Probably 4 ☐ Unknown δ 24b. Were autopsy findings available prior to completion of cause of death? r this certificete has been si 24a. Was an autopsy performed? Completed 1 ☐ Yes 2 ☐ No Division of Vital Hospitai or Attending Physician: 24 hours efter death. Be 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No illed in by the f 3 🗌 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours e To the Funeral C completely filled retifying Physicien: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) and manner as stated.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier 29b. Signature end title of cartifier

M.D.

son who completed cause of death (ten-23a) (Type, Print)

M.D.

32. Registrar's Signature

State Registrar 30. Name and eddress of p

31. Date filed (Month, Day, Year)

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	•	For State of Ma	ryland / Dep <i>Ce</i>	artment of Heartificate of E	ealth and Me Death	ntal Hygie	2004	08803
Physicia	an	1. Decedent's Name (First, Middle, Last) ANN TAWNEY		17.40	2	Date of Death Month	Day Year	3. Time of Death
/Medic Examin	_	4a. Facility Name (If not institution, give street and number) UNIV OF MOUNTAMEDS PIPOL, 22	S. arcenes	4b. City, Town, or	Location of Death		4c. County of Deat	n
Funeral Director			(In yrs. last birthday,	,	If Under 24 Hrs. 8 Hours Min.	Date of Birth (Month, Day,)	Baltimo	nplace (State or Foreign untry) hington, DC
ס		Usual Residence of Decedent	10c. City, Town or L	ocation		ian. 30,	1931 was	10d. Inside City Limits
the Mary 28a-f eh	Director	Maryland Worcester	0cear	City		100	g. Citizen of What Co	1 ☐ Yes 2X No untry?
h with 23a or	a Di	9821 Keyser Point Road,	Unit 6	21842			USA	
rs after deel	by Funerai	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 1 □ Yes 2 ☑ No II Yes, Give 2 □ Widowed 4 □ Divorced	ver in U.S. 13.	Was Decedent of His	spanic Origin? (Specific, Mexican, Puerto Ric Specify:	y Yes or No- can, etc.)	14. Race - Ame Black, White Specify: Whi	e, etc.
portition of the proof of the control of the contro	Completed I	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5-	(Give	edent's Usuai Occupa e kind of work done di DO NOT use retired)	uring most of working	16	3b. Kind of Business/	ndustry
Hygier ther th	e Cor	12 17. Father's Name (First, Middle, Last)	Sch	ool Bus Dr	iver 18. Mother's Name (/	First, Middle, Ma	Education	
uld be Mental rked o	To Be	Wheeler Morrison			Ann Q		00 000	
2 should have he mand have in small he mand he		19a. Informant's Name/Relationship (Type, Print)		ling Address (Street a				
1 and 1 and Health Health 27 other tr		Donna Marie Spicer/ Daughte 20a. Method of Disposition		66 Cliff Societion (Name of ematory or other place			ville, MD Oc. Location - City or	
mit. Pages 1 partment of He sortant: If iten finjury of oth	1	1 ☐ Burial 2 ☑Cremation 3 ☐ Removal from State • 4 ☐ Donation 5 ☐ Other (Specify)		itan Cremai		\ "	lexandria.	Virginia
permit. Departminents importa		21. Signature of Funeral Service Licenses	r 5	22. Name and Address rancis J. UU Univers	s of Facility Collins Fu Sity Blvd.	ineral H	lome Inc.	. MD 20901
Physician /Medical Examiner		resulting in death) Due to (or as a	the death. Do not en	nter the mode of dying				Approximate Interval Between Onset and Death 2 WEEKS
icate be executed physicien and sthe burial-transit	cal Examiner	cause. Enter Underlying Cause (Discase or injury that initiated events c.	consequence of):					
tificate tg phys	ਰ	d.					T 1	
To the Hospitel or Attending Physicien: The law requires that the death certific within 24 hours attended to the form the form of the Funeral Director. After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 2 → No 9 □ Unknown	2 ☐ Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)			23d. Date of deli Month	very Day Year
w requires that to been signed by should be detail	ρ	Part II. Other significant conditions contributing to death bu	t not resulting in the	underlying cause give	n in Part I.		cco use contribute to	the cause of death?
The law recate has been page 2 sho	Completed					24a. Was an autopsy performe 1 ☐ Yes 25	prior to death?	topsy findings available completion of cause of 2 No
sicien: 1 certifical rector, p	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatier	nt 2 ☐ ER/Outpatie	ent 3 DOA Othe	26. Place of Death (6		ce 6 □Other (Spec	
ding Phy th. : After this funeral d		27. Manner of Death 15 Natural 5 Pending 2 Accident investigation 2 Accident investigation	/ 28b. Time	of 28c. Injury Work			r injury occurred	ary)
To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune funeral presents.	Certification:	o Clossis S Could not be	ry - At home, farm, s . (Specify)	treet, factory, office	28	Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,
n 24 hour n 24 hour ne Funera	edicai (29a. Certifier (Check only one) Certifying Physicien: To the best of 2 Medicel Exeminer: On the basis of and manner state	examination and/or is	ath occurred at the time investigation, in my op	e, date and place, and inion, death occurred	d due to the cau at the time, date	se(s) and manner as e and place, and due	stated. to the cause(s)
To the within To the comp	W	29b. Signature and title of certifier MD MD		29c. License		290	1. Date signed (Month	o, Day, Year)
4		30. Name and address of person who completed cause of de C. HUYNH, MD 22 Sc	aim Gree	enest, P	allmine	MDZ	21201	
Sta Registr		31. Date filed (Month, Day, Year) MAR 0 1 2004 32. Begistra	r's Signature	Sports	/			

Amended #s 20b, 23a(a), 23a(b); nls, 03/02/04, Allegany Co.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2001

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		1 - Stete Registrar			Cei	tificate of	Death		Reg. No.	74 0000
Physic /Medi		1. Decedent's Name (First, Midd Gary D. Tipton, Sr						2. Date of Da Month Februa	ary 29, 200	
Exami		4e. Facility Name (If not institution 14708 Mt. Savage		umber)			or Location of Death Mt. Savage		4c. County of Allegan	
Funeral Director		5. Social Security Number 218-38-0536	6. Sex 150 M 2□ F	7. Age (In yrs 63	. last birthday) Yrs.	If Under 1 Year Months Days		8. Date of Bird 05-Arpr-	th Y9²41 ^{r)}	9. Birthplace (State or Foreig Maryland
Maryland	tor	Usual Residence of Decedent 10a. State 10b. County Maryland Alle	gany		ity, Town or Lo Savage	cation				10d. Inside City Limit:
with the 3e or 28e st be noti	i Director	10e. Street and Number 1470	8 Mt. Savag	e Rd., NW		10f. Zip Code 21545-			10g. Citizen of Wh	nat Country?
ad within 72 hours after death gjene. er then "natural", or Items 2 i, tte Modical Exercitier mu	by Funera	11. Marital Status 1 Never Married 2 Mar 3 Widowed 4 Divorce	rried 1 Tes	2 □ No live		Was Decedent of f Yes, specify Cub 1 ☐ Yes 2 🛱 No	Hispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	- 14. Race Black, Specify	- American Indian, White, etc. /hite
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural", or items 23e or 28a-f show many injury or other traumatic event, the Maryland Examinating must be notified at some.	Completed by Funeral	15. Decede (Specify only highe Elementary/Secondary (0-12)	nt's Education set grade completed		16a. Deced	DO NOT use retire	during most of wor	king	16b. Kind of Bus	iness/Industry
should be filed within and Mental Hygiene. marked other then amatic event, the M.	To Be Co	17. Father's Name (First, Middle George W. Tipton					18. Mother's Nam Eileen J. Lo		Maiden Sumame,)
and 2 should be file salth and Mental Hy n 27 is marked oth ier traumatic event	-	19a. Informant's Name/Relation Georgia Tipton	ship (Type, Print) wife		12708 K	n Address (Sie R	and Number or Ru	ral Route Numbe	er, City or Town, S Maryla	nd 21545-
permit. Pages 1 ar Department of Hes Important: If Item eny injury or othe		20a. Method of Disposition 1		State MC	Place of Dispo cemetery, crer inviding Ve	sition (Name of matory or other pla leran's Cem		Date Cb-2004-F	20c. Location - C lintstone	ity or Town, State Maryland
permit. Pag Department Important: h eny injury o		21. Signature of Funeral Service	Licenson	ust		rst Funeral	ess of Facility Home, 57 Fre	ost Ave., F	rostburg, M	D 21532
Physician /Medical		23a. Part 1. Enter the disease, of shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	_ a. A	caused the dea each line.	ophi	er the mode of dy	ing, such as cardiac	or respiratory and	rrest. 1 05 i 5	Approximate Interval Between Onset and Death 5-6 years
certificate be executed to ding physician and see as the burial-transit	/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	6	o (or as a conse						-5-64R
	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live	utcome of pregr birth 2 Pet gnant at time of nown	aldeath 3	Ectopic pregnand Other (specify)	су		23d. Date Mont	,
The law requires that the death ate has been signed by the atten page 2 should be detached for u	þ	Part II. Other significant condit	ions contributing to	death but not re	sulting in the u	nderlying cause g	ven in Part I.	23e. Did to	1.0	oute to the cause of death? Probably 4 □Unknow
8 S CA	Completed								osy pri rmed? de 22 No 1	ere autopsy findings availabl or to completion of cause of ath? Yes 210 No
Physician: r this certific ral director,	To Be	25. Was case referred to medic examiner? 1 Yes 2 No	Hospital:	Inpatient 2	☐ ER/Outpatier	et 3 DOA	26. Place of Dea ther: 4 Nursing H	1.4	<i>ine)</i> dence 6 ∐Other	(Specify)
Attending Phir death. ector: After th		27. Manper of enth 1 Natural 5 Pend 2 Accident inves	28a. Date (Mo	e of Injury nth, Day Year)	28b. Time of Injury	Wo	iry at ork?] Yes 2 □ No	28d. escribe l	now injury occurred	1
Dir Dir	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deten	mined 286. Place	ce of Injury - At I ding, etc. (Spec	nome, farm, str ify)	eet, factory, office		28f. Location (S City or Tox		or Rural Route Number,
ne Hospital or 24 hours afte ne Funeral Dir bletely filled in	edicai (ner as stated. d due to the cause(s)
VI To the To the Complete	W	29b. Signature and title of certifi		(h)		Do	0 252	- /	29d. Date signed	Month, Day, Year) 2/04
	ate	30. Name and address of person 31. Date filed (Month, Day, Yea.	1) 32.	CSS Car Registrar's Sign	din	Print)	r 6 lens	st. G	im berlan	d mo 2502
Regist		MAR 0 2	2004 50	in	B	Spork	/			

			1 - For State Registrer	State of Mary		artment of H			giene 0 0	4 08805
	Physici	an	1. Decedent's Name (First, Middle, Las		1			2. Date of Dea	ath Day Y	3. Time of Death
	/Medio		Naomi Joseph 4a. Facility Name (If not institution, give	nine Tichi	neı.	4b. City, Town, or	Location of De	March	01 20 4c. County of	04 2:10P M
			1836 Mt. Zion F			Swanto			Garre	tt
	Funeral Director		5. Social Security Number 6. Security Number 214-32-3661	7. Age (In	yrs. last birthday) 66 Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M	in. 8. Date of Birt (Month, Da)	1937	Birthplace (State or Foreign Country) WV
	yland		10a. State 10b. County	100	c. City, Town or Lo	ecation				10d. Inside City Limits
	8e-fet	Director	MD Garret	t	Swantor	1				1 ☐ Yes 2X No
	with the		10e. Street and Number 1836 Mt. Zion	Pood		10f. Zip Code	1		10g. Citizen of Wha	at Country?
	me 23	Funeral	11. Marital Status	12. Was Decedent Ever	in U.S. 13.	2156 Was Decedent of Hi		(Specify Yes or No- erto Rican, etc.)	U.S.A.	American Indian,
920	be filed within 72 hours after death with the Maryland that Hygiene. Id other than "netural", or itame 23a or 28e-f ehow event, the McGral Exprainer must be indiffied at	þ	1 ☐ Never Married 2 🛣 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1		37	n, Mexican, Pu Specify:	èrto Rican, etc.)		White, etc. White
5-0	"natur	Completed	15. Decedent's Edi (Specify only highest grad	ucation de completed)	16a. Deced	dent's Usual Occupa kind of work done of DO NOT use retired	ation furing most of v	vorking	16b. Kind of Busin	ness/Industry
121	within iene. than the M	ршр	Elementary/Secondary (0-12)	College (1-4or 5+)		ousewife)		Homema	ker
b	be filed within tal Hygiene. d other than '	Be C	17. Father's Name (First, Middle, Last)				18. Mother's N	lame (First, Middle,		
ylaı	should be ind Mental i marked oumatic ev	70	Luther Wilt				Marga		Ray	
Mar	d 2 Tris		19a. Informant's Name/Relationship (T) Stanley F. Ti					Rural Route Number		
Ē,	s 1 and if Health itam 27 other tr		20a. Method of Disposition	20	Db. Place of Dispo		!	Date Date	20c. Location · Cit	21561 y or Town, State
<u><u>E</u></u>	Page nent o ant: If ury or		1 X Burial 2 ☐ Cremation 3 ☐ i `4 ☐ Donation 5 ☐ Other (Specify)	Removal from State		Cemeter	· 1	04/04	Swanton	, MD
Baltimore, Maryland 21215-0036	permit. Pages 1 an Department of Heal Important: If itam 2 any injury or other 2062.		21. Signature of Funeral Service Licens	Burdoch				Burdock Kitzmi		
			23a. Part . Enter the disease, or comp shock, or heart failure. List only o	lications that caused the ne cause on each line.	death. Do not ent	er the mode of dying	g, such as card	iac or respiratory arr	est,	Approximate Interval Between
Z	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. atherosc. Due to (or as a cor	lerotic	cardio	vascu1	ar disea	ase	Onset and Death Months
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	p #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a cor		CIAI DC.	101051	5		/ Ino
	icate be executed physician and s the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Hyperte	nsion nsequence of):					yrs
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.O. Box	requires that the death certific leen signed by the attending p hould be detached for use as	by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcome of pro 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetel death 3□	Ectopic pregnancy Other (specify)			23d. Date of Month	f delivery Day Year
٣.	that the ned by detac	y Ph	Part II. Other significent conditions co	ntributing to death but not	resulting in the ur	derlying cause give	n in Part I.	23e. Did tol	pacco use contribut	te to the cause of death?
rds	w requires been signe should be	ed b						1 🗆 Ye	es 2. X No 3. □	Probably 4 Unknown
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of	.e. 5	5	1 ☐ Yes 2X No	lospital: 1 ☐ Inpatient 28a. Date of Injury	2 ER/Outpatient 28b. Time of	3 □ DOA Othe 28c. Injury	4 Nursing	Home 5 Reside	ence 6 Other (S	Specify)
on	Attanding Ph ar death. actor: After th by the funeral	atlon	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Yea	r) Injury	Work	? es 2 □ No	Ecd. Bosonibo no	w injury occurred	
É	i Sir e	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Sp.	At home, farm, stre	et, factory, office		28f. Location (St City or Town	reet and Number o	r Rural Route Number,
	To tha Hospital within 24 hours a To the Funarel i completely filled	edical (29a. Certifier 1 IX Certifying Physical Check only one) 2 ☐ Medicel Exemi	sicien: To the best of my ner: On the basis of exar and manner stated.	knowledge, death nination and/or inv	occurred at the time estigation, in my op	e, date and placinion, death occ	ce, and due to the ca curred at the time, da	ause(s) and manne ate and place, and	r as stated. due to the cause(s)
)	To tha h within 2 To the I complet	×	29b. Signature and title of confities	hter		29c. License D300			9d. Date signed (M 03-01-20	
			30. Name and address of person who co	empleted cause of death	(Item 23a) (Type, F	Print)				
	-01-		Donald R. Rich	ter, M.D.		emoria1	Drive	0aklan	d, MD 2	1550
	Sta Registra		MAR -	2 2004	Cure M	Angel D				

State of Maryland / Department of Health and Mental Hygiene 2004 08806 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** WILLIAM THADDEUS THOMAS FEBRUARY 24, 2004 6:00 PM /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death CORSICA HILLS NURSING HOME CENTREVILLE QUEEN ANNE'S 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 9. Birthplace (State or Foreign Days Hours 1 X M 2 □ F Director 213-10-5943 93 MARYLAND DEC. 10, 1910 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 28e-f show 10d. Inside City Limits QUEEN ANNE'S Director CENTREVILLE 1 Yes 2 No 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? other traumatic event, the Medical Eventioner must be 113 SOUTH LIBERTY STREET or itsms 23a 21617 USA by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) Cotlege (1-4or 5+) 12 INSURANCE AGENT INSURANCE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ROBERT WRIGHT THOMAS ANNIE HARPER COLLINS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 l MARGUERITE THOMAS/ WIFE 113 S. LIBERTY ST., CENTREVILLE, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATORY | 02/26/2004 STEVENSVILLE, MD 21. Signature of Funginal Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 408 S. LIBERTY ST., CENTREVILLE, MD 21617 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final Physician disease or condition resulting in death) or oracy ac /Medical Due to (or as a consequence of): Examiner DUHUSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of) Examiner erebrovascerlar Due to (or as a consequence of): Physician/Medical use as the 0 IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 0 go in the past 12 months? Month 4 Pregnant at time of death Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 5 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 TYes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed' this certificate 2 No 2 X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Vursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes ₽ 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident within 24 hours after death.

To the Funeral Director: After completely filled in by the funeral Management of the funeral forms of the funeral function of the funeral function of the funeral function of the funeral function of the functi 9 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide dinby 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2540 Ce 31. Date filed (Month, Day, Year) wille Rd State 32. Registrar's Signature FEB Registrar Sparke

Box

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Vita

of

Division

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OHMH 17 Rev 1/2001

ORIGINAL

		For State Registrar	AMEND#26perMD	State of Ma 3/5/04,BMW,M	ryland / De	epartme Certifica	nt of Health and te of Death	Mental Hy	giene 2	004	088
Physic	ian		lame (First, Middle, Last					2. Date of D Month	Day	Yeer	3. Time of Dea
/Med	ical		ris Gerald I			4b. Cit	y, Town, or Location of Dea	March	- i	nty of Death	5:55 F
Exami	iner		aven Nursin		Inc.		delphi				George's
unera		5. Social Securi	-8573 6. Se		(In yrs. last birthe	day) If Und	er 1 Year If Under 24 Hr	1. (Month, D	irth	9. Birtha	olece (State or For ntry)
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Hed a	tor	Marylan	d Montgo	merv	Silv	er Spi	ing				1 ☐ Yes 2 🔀
or 28	Director	10e. Street and	Number			10f. 2	Zip Code		10g. Citizen		ntry?
s 23a	ral	-	Redmiles Di		Superia II C	12 Was Day	20905	Chachy Vos or N		USA Race - Americ	can Indian
od other than "natural", or items 23s or 28s-f show event, the Medical Examiner must be notified at	by Funeral		us Married 2 [3] Marned ed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ☑Yes 2 ☐ N If Yes, Give Year or Dates: 1	0		edent of Hispanic Origin? (pecify Cuban, Mexican, Pue 2 2 No Specify:	erto Rican, etc.)		Black, White,	etc.
natura Jigal E	Completed	(5	15. Decedent's Ed Specify only highest grad	ucation	16a. D	ecedent's U: Give kind of tife. DO NOT	sual Occupation work done during most of w	orking	16b. Kind of	Business/In	dustry
other than	mp	Elementary/S	Secondary (0-12)	College (1-4or 5-	+)	Accou			IIti	lity	
other	a)	17. Father's Na	me (First, Middle, Last)			110000		ame (First, Middl			
arked o	To B	Lewi	s Perrie Un	kle			Kather	cine Mar	ia Beal	1	
or nealth and Ment litem 27 is marked r other traumatic e	1	19a. Informant	's Name/Relationship (7	ype, Print)			ss (Street and Number or F				
m 27 her tr		Rober 20a, Method of	ta G. Unkle	/_Wife	20b. Place of D		dmiles Drive	Silver	Spring 20c. Location		
F of		1 🗆 Burial	2 ☑ Cremation 3 □		cemetery,	crematory o	rother place) Man	cch 3,			
important: If its any injury or of			on 5 Other (Specify of Funeral Service Licen:	7 7	Metropo	22 Name	and Address of Facility	2004			Virginia
impo any i		21. Signature	Turing Salvice Lican	Trenda		Franc	is J. Collins niversity Bly	Funera	1 Home	Inc.	т MD 209
ysiciar Medica amine	ı	shock, or Immediate Car disease or con resulting in dea	heart failure. List only ouse (Final dition ath)	a. Osteomye Due to (or as a	e. 11t1s of a consequence of	Left lar D					Approximate Interval Between Onset and Deat
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ied by the attending plidetached for use as t	Physician/Medical	IF FEMALE: 23b. Was dece in the pas 1 \(\supersection\) Yes 9 \(\supersection\) Unkn	t 12 months? 2 \(\subseteq No	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death	3 □Ectopic 5 □ Other				Date of delive Month	ery Day Year
00	þ		ignificant conditions co stive Heart	•	al not resulting in t	he underlyin	g cause given in Part I.				he cause of death pably 4 X Unkn
cate has been si page 2 should	Completed	Parki	nson's Dise	ase				per	opsy formed?	b. Were auto prior to co death? 1 \sum Yes	opsy findings avail impletion of cause
certificate	0		referred to medical				26. Place of D	1 ☐ Yes eath (Check only		T Tes	2 140
6 G	To B	examiner?	2 <u>√</u> №	Hospital: Ze Impatio	nt 2 ☐ ER/Outp	atient 3	DOA Other: 4 Nursing	Home 5 ☐ Res	sidence 6 🗆 (Other (Specil	(y)
		27. Manner of 1 ☑ Natura 2 ☐ Accide	I 5 ☐ Pending investigation		y Year) 28b. Tir	ne of ury M	28c. Injury at Work? 1 Yes 2 No	28d. Describe	how injury occ	curred	
arr. rr: After th		3 Suicid		28e. Place of Inju- building, etc	ry - At home, farn . (Specify)	n, street, fact	ory, office		(Street and Nu own, State)	mber or Aura	al Route Number,
deam. ctor: After / the funer	ertific	4 🗆 Homio	100	Colorest Section 1							
deam. ctor: After / the funer	dical Certification:	4 Homic	1€ Certifying Ph		examination and/		ed at the time, date and pla on, in my opinion, death oc				
death. :tor: After / the funer	Medical Certific	29a. Certifier (Check oni	1€ Certifying Ph	iner: On the basis of	examination and/	or investigati				e, and due to	o the cause(s)
within 24 hours after death. To the Funeral Director: After completely filled in by the funer.		29a. Certifier (Check oni	ti⊈ Certifying Ph y 2 Medical Exam	iner: On the basis of	examination and/	or investigati	on, in my opinion, death oc 29c. License number		29d. Date sig	ned (Month,	Day, Year)
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	1_ For		Plea	se Type or State of	Print of Mai	i n B l ryland	/ Depa	ırtmen	t of H	lealth	and N	II Copies A Mental Hygid	re Leg	ible.	088	3 U S
	Regis	rtrar					Cer	tificate	e of l	Death		Reg	. No.	0 4	O O C) () (
Physician	1. Decede	nt's Name	e (First, Middle	, Last)								2. Date of Death Month	Day	Year	3. Time of	
/Medical		V	onda	Ε.	Ube	e1						Februar	y 29,	2004	12:42	2 P M
Examiner	4a. Fecility	Name (f	f not institution	, give street and nu	ımber)			4b. City,	Town, or	Location	of Death		4c. Count	y of Death		
	10	0603	Malone	Street				Sil	ver	Spri			Mon	tgome	ry	
Funeral	5. Social S	ecurity N	lumber	6. Sex	7. Age	(In yrs. la	st birthday)	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day, 1	(ear)	9. Birth	place (State o	r Foreign
Director	413-2	22-07	793	1 ☐ M 2 🙀 F		82	Yrs.	WOTHERS	Days	riours	IVIII.	April 26	1921		tucky	
	Usual Res	idence of	Decedent													
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Baltimore, Maryland 21215-0036

Director		413-22-0793	82	Yrs	•			April	26 , 1	921 K	entucky	
p .		Usual Residence of Decedent	10. 00									
inyla.	_	10a. State 10b. County	10c. Cit	y, Town o	r Location						10d. Inside City Limits	
Ma	호	Maryland Montgo	omerv	Silve	er Spri	ne					1 ☐ Yes 2 ☑ No	
r 28	ě	10e. Street and Number			10f. Zip				10g. Cit	izen of What (Country?	
th with	Funeral Director	10603 Malone Stre	eet			20902				USA		
ems	ne	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	.S. 1	3. Was Deced	ent of Hispa	anic Origin? (S	pecify Yes or N to Rican, etc.)	14. Race - American Indian, Black, White, etc.			
afte or It	F	1 Never Married 2 Married	1 ☐ Yes 2 ☑ No If Yes, Give		1 ☐ Yes 2		Specity:	, , , , , , , , , , , , , , , , , , , ,				
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in 72 "nat	Completed	15. Decedent's 8 (Specify only highest gi	rade completed)	(G	ecedent's Usua live kind of wor e. DO NOT us	k done duri		rking	16b. K	ind of Busines	ss/Industry	
with than is	E	Elementary/Secondary (0-12)	College (1-4or 5+) 2		Secreta	1237			For	laral (Government	
Hyg Hyg other	0	17. Father's Name (First, Middle, Las			Decret		. Mother's Nar	me (First, Middle			overiment	
ld be ental ked c ev	To B	John R	. Thrasher				Emma I.	. Hicks				
shound M	-	19a. Informant's Name/Relationship		19b. Ma	ailing Address	(Street and		ural Route Numi	ber, City o	r Town, State,	, Zip Code)	
nd 2 alith a 27 lu r tra		Rita Dopp/ Daugh	ter	56	4 North	West	Shelh	v Terra	ca I	aka Ci	ty, FL 32055	
s 1 a f Hea item othe		20a. Method of Disposition	20b. P	lace of Dis	sposition (Nam	e of	Mana	pate h 5,			or Town, State	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural", or Items 23a or 28a-f show amportent: if item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Modical Exemples must be notified at once.		1 Burial 2 □ Cremation 3 '4 □ Donation 5 □ Other (Special	Themoval from State		crematory or of con Nat Cemete	ional			Arli	ngton.	Virginia	
permit. Departr Imports any inju		21. Signature of Funeral Service Lice	,	1000	22. Name and	d ddress o	of Facility			-377		
89559		Kickend L.	Ha45		rrancis 500 Uni	versi	tv Blv	Funera	1 Hon Silve	ne Inc. er Spri	ng, MD 20901	
		23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that caused the death	h. Do not	enter the mode	of dying, s	such as cardiad	or respiratory	arrest,	· · · · · · ·	Approximate Interval Between	
Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Pneumonia										
/Medical		resulting in death)	Due to (or as a consequ	uence of):							4-6 weeks	
Examiner												
·	Jer	Sequentially list conditions,	b. Due to (or as a consequ	uence of								
uted d ansit	Ē	cause. Enter Underlying Cause (Disease or injury that initiated events										
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aath certificate be executed attending physicien and for use as the burial-transit	by Physiclan/Medical		d									
tifica ng ph as th	led							7.71		participe.		
h cer andir use	S	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna		2 🗆 🗆					23d. Date of de	elivery	
death	icla	in the past 12 months? 1 \(\text{Live birth} \) 2 \(\text{Fetal death} \) 3 \(\text{Ectopic pregnancy} \) 1 \(\text{Yes} \) 2 \(\text{No} \) No 1 \(\text{Live birth} \) 2 \(\text{Fetal death} \) 3 \(\text{Ectopic pregnancy} \) 5 \(\text{Other} \) (specify) \(\text{Live birth} \) 2 \(\text{Pregnant at time of death} \) 5 \(\text{Other} \) (specify) \(\text{Live birth} \) 2 \(\text{Live birth} \) 2 \(\text{Live birth} \) 2 \(\text{Live birth} \) 2 \(\text{Live birth} \) 3 \(\text{Live birth} \) 2 \(\text{Live birth} \) 3 \(\text{Live birth} \) 2 \(\text{Live birth} \) 3 \(\text{Live birth} \) 2 \(\text{Live birth} \) 3 \(\text{Live birth} \) 2 \(\text{Live birth} \) 3 \(\text{Live birth} \) 2 \(\text{Live birth} \) 3 \(\text{Live birth} \) 2 \(\text{Live birth} \) 3 \(\text{Live birth} \) 3 \(\text{Live birth} \) 2 \(\text{Live birth} \) 3 \(\text{Live birth} \) 2 \(\text{Live birth} \) 3 \(\text{Live birth} \) 3 \(\text{Live birth} \) 3 \(\text{Live birth} \) 2 \(\text{Live birth} \) 3 \(\text{Live birth} \) 2 \(\text{Live birth} \) 3 \(Live birt								Month Day Year		
res that the de signed by the a be detached f	hys	9 Unknown										
s tha	y P	Part II. Other significant conditions	contributing to death but not resu	ulting in the	e underlying ca	use given ii	n Part I.	23e. Did	tobacco u	se contribute	to the cause of death?	
w require been sig should b	ed t	Dementia						1 🗆	Yes 2	⊠No 3∏F	Probably 4 Dunknown	
s bee	mpleted							24a. Was	an	24b. Were a	autopsy findings available	
The lav								auto	ormed?	prior to death?	completion of cause of	
iffication, p	e Co	25. Was case referred to medical				26	Place of Dog	1 L Yes	2 <u>K</u> No	1 🗆 Ye	s 2 No	
s cert	ToB	examiner? 1 ☐ Yes 2 🔀 No	Hospital:	ER/Outpat	tient_3 DO	Other		th (Check only lome 5% Res				
Phy or this oral o		27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time		ic. Injury at Work?	4 🗀 IAGISING H	28d. Describe			өспу)	
ath. ath. rr: Afte	Certification:	1 Natural 5 Pending 2 Accident investigation		Injur	М		2 🗆 No			,		
r Atte	tific	3 ☐ Suicide 6 ☐ Could not to determined		me, farm.	street, factory,	office	1	28f. Location (City or To			Rural Route Number,	
tel o	Cer							0.1,7 0.7 0	www.	1		
To the Hospitel or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check only one) 1 Certifying P 2 Medical Exe	hysician: To the best of my know miner: On the basis of examinat and marker stated.	wledge, de tion and/or	eath occurred a nivestigation,	t the time, o	date and place on, death occu	, and due to the rred at the time,	cause(s) date and	and manner a place, and du	as stated. le to the cause(s)	
Fo th within Fo th	Me	29b. Signature and title of certifier	1		29c.	License nu	ımber		29d. Dat	e signed (Mor	nth, Day, Year)	
10		1 Welly o	Masa	L	1)	D2223	5		Ма	rch 4,	2004	
·		30. Name and address of person who					-					
C.	20	Wesley Mason M.] 31. Date filed (Month, Day, Year)	D. 10810 Co 32. Registrar's Signal	nneci			, Kens	sington,	MD	2089	5	
Sta Registr		MAR 0 5 20		19	200	cks						

Division of Vital Records, P.O. Box 68760,

		1	For State Registrar	State of Mary	land / Dep		t of Hea	alth and			2004	08809					
1	Physici	an	Decedent's Name (First, Middle, La Leo Vanscoy	st)					2. Date of De Month Febuary	Day	Year 2004	3. Time of Death 10:50P					
, ,	/Medic Examin	_	4a. Facility Name (If not institution, giv	e street and number)		4b. City,	Town, or Lo	cation of Dea			County of Deat						
			Frederick Memori				dericl			Fr	ederick						
16 A	Funeral Director		300-22-0231	Sex 7. Age (Ir	yrs. last birthday. 34 Yrs.	If Under Months		f Under 24 Hr Hours Mir		4, 19	20 Wes	nplace (State or Foreign untry) t Virginia					
	pue *	}	Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or L	ocation						10d. Inside City Limits					
	Manyli f sho	ō	Md. Montgon	mery	Silver S	pring						1 ☐ Yes 2 🙀 No					
	288-	rect	10e. Street and Number			10f. Zip	Code			10g. Citiz	zen of What Co	untry?					
	N with	D	9700 Forest Glen	Court			20910)		Uni	ted Sta	ites					
Maryland 21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. do other than "natural", or itame 23a or 28a-f show event, the Medical Evanti at much to collified at	by Funeral Director	11. Marital Status 1 ☐ Never Mamed 2 ☐ Married 3 ঐMidowed 4 ☐ Divorced	12. Was Decedent Eve Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates:	1943- 1946	Was Deced If Yes, spec		anic Origin? (Mexican, Pue Specify:	Specify Yes or No into Rican, etc.)		14. Race - Ame Black, White Specify: Wh						
Ą	2 hou	ted	15. Decedent's E	ducation	16a. Dece	edent's Usua	al Occupatio	on ing most of w	odena	16b. Kir	nd of Business/I	Industry					
215	ben 'n	ple	(Specify only highest gri	College (1-4or 5+)	life.	DO NOT us	se retired)	ing most or w	orking								
7	e filed within al Hygiene. I other than vent, the Me	Completed			Pro	gramme											
ng	tal Hy d oth	Be	17. Father's Name (First, Middle, Last Dennis Vanscoy)						, Maiden	Sumame)						
<u>₹</u>	should be and Mental marked of umatic ev	ှင	-	7 0:0	405 14 7			Lela S			. T	To Contain					
Mar	12 sh h and 7 is m traum		19a. Informant's Name/Relationship (David Vanscoy (Son)													
	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		20a. Method of Disposition		20b. Place of Disp cemetery, cre				Date								
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any njury or other		1 ☐ Burial 2 【Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Speci	_inemoval from State	сөтөтөгу, сге Metropol				29,	۸1	1	***					
Ē	ortan	-	21. Signature of Funeral Service Lice	- A				of Facility D	004 eVol Fund	Alex eral	Home	va.					
Ba	Ded on a		Muchen	(1) Luly								d. 20877					
	Physician /Medical Examiner	ner	23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	~ 1	onsequence of):	243	924	1045	· is spiratory a	india,	79-7	Interval Between Onset and Death					
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O. Box	The law requires that the death certificate to the law requires that the attending physicage 2 should be detached for use as the topical to the law that the law that the law readers.	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of p 1 Live birth 2 C 4 Pregnant at tim 9 Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)					3d. Date of deli Month	ivery Day Year					
rds, P.	w requires that been signed b should be deta	by	Part II. Other significant conditions	contributing to death but n	ot resulting in the	underlying c	ause given i	in Part I.									
Vital Records,		Completed	Proumo	n= -10	Pr los	W.E.	1-	be	24a. Was auto perfo 1 Yes		prior to death?	completion of cause of					
/ita	ilcian: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	11				6. Place of D	eath (Check only o	one)							
of\	Physician: this certific ral director.	၉	1 Yes Z	Hospital:	2 ER/Outpatie		or framework to the		-			cify)					
		atlon:	27. Manner of Death Autural 5 Pending 2 Accident investigation		ear) 28b. Time Injury	M 2	28c. Injury at Work? 1 ☐ Yes	t s 2 □No	28a. Describe	now injury	23d. Date of delivery Month Day Year cco use contribute to the cause of death? 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No cce 6 Other (Specify) rinjury occurred						
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Afte completely filled in by the fune	Certification:	3 Suicide 6 Could not 4 Homicide determined		- At home, farm, s Specify)	treet, factory	y, office		28f. Location (City or To			ral Route Number,					
	e Hospi 124 hou e Funer letely fill	Medical			amination and/or i												
	To the within 2 To the comple	Ž	29b. Signature and title of certifier			290	c. License n	umber		29d. Date	e signed (Month	n, Day, Year)					
	1.1		ino 1	Msiren	·m)		1)	737	3	2/2	27/04						
1	10-11		30. Name and address of person who	completed cause of deat	h (Item 23a) (Type	o, Print)	>7/ 1	Heine	e Ana	+	10,001	rle max					
	Sta Regist		31. Date filed (Month, Day, Year) MAR 0 2 2	32. Registrar's	Signature	Sp	ach	1	1			, ,					

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day Asunta Herbert Willis рм February 27, 2004 /Medical 7:30 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Yeer)
Nov. 12, 1 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Birthplace (Stete or Foreign
Country) 1 □ M 2 1 F Director 217-48-1681 90 1913 Washington, Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits Completed by Funeral Director 1 Tyes 2 Tho Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 9707 Old Georgetown Road or items 23a 20814 USA Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 □ Divorced 'natural' Pages 1 and 2 should be filed within 72 hour frment of Health and Mental Hygiene.
 Health and Mental Hygiene.
 Health and Tis marked other than "natural jury or gither traumatic event, the Medical Es-16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ٥ Harry Herbert Blanche Rocca 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan O'Neill/ Daughter 11811 Glen Mill Road, Potomac, MD 20854 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 2, March 2004 permit. Page Department of Importent: If any injury or once. Monocacy Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Beallsville, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or combidations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Pulmonan **Physician** empoli 2 days resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed the attending physicien and Due to (or as a consequence of): P.O. Box 68760, Physician/Medical as the IF FEMALE: use. 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy certificate 1 Yes 2 No 1 ☐ Yes 20 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No this After thi 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28c. Injury at Work? Medical Certification: 28b. Time of 28d. Describe how injury occurred 1 Anatural 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funerel Diractor: 6 Could not be 3 Suicide in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 56439 MD 10 M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) medical Center into Rockille, MD 20850 Turban, M.D. 31. Date filed (Month, Day, Year) MAR 01 32. Régistrar's Signature State Registrar

			1 - For State Registrar	State of M	laryland / Depa <i>Ce</i>	artment of I		d Mental Hy	giene				
	Physic		1. Decedent's Name (First, Middle, Las	E Month One Day 2 (ser									
	/Medi Exami		Tadeusz K. Walend 4a. Facility Name (If not institution, give 5904 Kingsford Pl.	street and number)	4b. City, Town, o			4c. County of Montgo	Death			
	Funeral Director			7. A	ge (In yrs. last birthday) 59 Yrs.	If Under 1 Year If Under 24 Hrs. 8. Date of Amonths Days Hours Min. April			Birth Day, Year) 1944 9. Birthplace (State or For Country) Poland				
	Maryland f show ied at	JO.	Usual Residence of Decedent 10a. State 10b. County Maryland Montgome	rv	10c. City, Town or Lo	cation				10d. Inside City Limits ↓□ Yes 2 □ No			
	h with the 13a or 28a-	ai Director	10e. Street and Number 5904 Kingsford Pl.		Deciresda	10f. Zip Code 2081	7		t0g. Citizen of Wha	A			
036	be filed within 72 hours after death with the Maryland tial Hygiene. ad other than "natural", or items 23a or 28a-f show event, if a Medical Evartirat must be rotified at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces' 1 Yes 2 If If Yes, Give 2 Year or Dates:	P No	Was Decedent of H f Yes, specify Cub	Hispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - Black, Specify:	American Indian, White, etc. White			
21215-0036	within 72 ho ene. then "natur ne Medical I	Completed	15. Decedent's Elementary/Secondary (0-12)	de completed) College (1-4or	(Give	lent's Usual Occup kind of work done DO NOT use retire	during most of v		16b Kind of Busin	ess/Industry			
Maryland 2	2 should be filed within and Mental Hygiene. Is marked other than sumatic event, tra M	To Be Co	17. Father's Name (First, Middle, Last) Edmund Walendowsk	5 + i	3342		18. Mother's Maria	lame (First, Middle,		America			
	es 1 and 2 should b of Health and Ment fitem 27 is marked r other traumatice		19a. Informant's Name/Relationship (7) Elias Walendowski- 20a. Method of Disposition		5904	Kingsfor		Rural Route Number Bethesda,	MD 20817				
Baltimore,	Pag nent ing		20a. Method of Disposition 1										
Ba	Departic Departic Imports any inju		23a. Part 1 Enter the disease, or comp	Wil	1	1800 New	Hampshi	re Ave. S	ilver Spi	cal Home			
* 400	Physician /Medical Examiner	her	shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Entir Uncertainty Cause (Disease or injury)	cer		Interval Between Onset and Death							
58760,	icate be executed physician and s the burial-transit	edical Examin	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence of):								
j.	it the death certific by the attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome 1☐Live birth 4☐Pregnant at 9☐ Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of Month	delivery Day Year			
ords, P	v requires that the been signed by t	by	Part II. Other significant conditions co	ntributing to death b	ut not resulting in the un	derlying cause give	en in Part I.			e to the cause of death?] Probably 4 (ŽŪnknown			
r	The law ate has b page 2 sl	Completed						24a. Whas ar autops perform 1 □ Yes 2	prior deatl				
	ding Phys n. After this funeral di	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 XNo 27. Manner of Death 1 XNatural 5 Pending 2 Accident investigation	ospital: 1 Inpatie 28a. Date of Inju (Month, Da		3 DOA Othe	er: 4 🗆 Nursing	Home 5 🖾 Reside	nce 6 Other (S	Specify)			
\leq	tai or Attands after death ai Director:	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injubulding, etc.	ury - At home, farm, stre c. (Specify)	et, factory, office		28f. Location (Str. City or Town,	eet and Number or State)	et and Number or Rural Route Number, State)			
	To the Hospital or At within 24 hours after or To the Funeral Directompletely filled in by	Medical	one)	ician: To the best ier: On the basis of and manner sta	of my knowledge, death examination and/or inve ited.	estigation, in my op	oinion, death occ	ce, and due to the ca curred at the time, da	use(s) and manner te and place, and o	as stated. due to the cause(s)			
1	To the within To the comple		29b. Signature and title of certifier	My r	1.D.	29c. License number 29d. Date signed (Month, Day, Year) D0059244 Feb. 28, 2004							
1.6			30. Neme and address of person who co G. Mery, M.D. 5622 31. Date filed (Month, Day, Year)	Shields	Dr. Bethesd		817						
	Sta Registr		MAR 0 1 2004		ar's Signature	Sparks	/						

State of Maryland / Department of Health and Mental Hygiene 20008813 For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 9, 2004 1:07 PM **Physician** 0scar н. Williford ebruary /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Doctor's Community Hospital Lanham Prince Georges If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 1 X M 2 ☐ F 75 Director Sept. 13, 1928North Carolina 245-36-8200 Usual Residence of Deceden 10d. Inside City Limits 10c. City, Town or Location r than "natural", or Itams 23a or 28e-f show the Medical Examiner must be notified at 10a State 10h County 17 Yes 2 □ No Director Maryland Prince Georges Bowie 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code 20720 U.S.A. 6203 Gibraltar Lane Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. hours after 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No 21215-0036 3 XWidowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation 72 (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) I Hygiene. filed within Elementary/Secondary (0-12) College (1-4or 5+) Furniture Salesman traumatic svent, 18. Mother's Name (First, Middle, Maiden Surname) should be fill the and Mental Hv Maryland 17. Father's Name (First, Middle, Last) Be ages 1 and 2 should be timent of Health and Mental's ent: If Item 27 is any or other 2 Williford Ida Thames 0scar Nelson Mae 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Davin James Williford/ Son 2946 McGee Way, Olney, Maryland Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 3/3/2004 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or once. Riverdale Baptist Upper Marlboro, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Robert E. Evans Funeral Home 21. Signature of Funeral Service Licensee John P. Karis 16000 Annapolis Road, Bowie, Maryland 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cerebon is ale IWK Physician /Medical Due to (or as a consequence of): IWK **Examiner** ESENCERIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ue to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the use as IE FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy ō in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 Yes 2 No detached Ö the 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Onknown Completed peen 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 autopsy has certificate 2 X No 1☐ Yes Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 XNo 70 this After thi 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Injury Hospital or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident To the Funeral Director: completely filled in by the t 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) determined 4 Homicide hours after within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investination in my color 29a. Certifie Medical On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and the MDD07195 0/ 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WERNER Havover Ykin (veen 20770 2500 31. Date liled (Month, Day, Year) 32. Raistrar's Signature State 02 2004 Registrar

			1 - State of Maryland / Department Certificat	nt of Health and M te of Death	Mental Hygien		08814	
	Dhysisi	,	Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death	
ı	Physici /Media		Mildred Ann Wineberger		February 2	29, 2004	11:52 ^{A м}	
P	Examir	er		Town, or Location of Death	4	c. County of Deat		
6	Francis			apolis r 1 Year If Under 24 Hrs.	8. Date of Birth	nne Arun		
В	Funeral Director		577-38-9447 1 M 2 TF 73 Yrs. Months		(Month, Day, Yea	930 Okla	hplace (State or Foreign	
	pu .		Usual Residence of Decedent		Dec. 13, 1	930 OK18		
	Aaryla Sho	5	Total Stay, Total St. Education				10d. Inside City Limits 1 ☐ Yes 2 ☐ No	
	the h	Directo	10e. Street and Number 10f. Zip	Code	100.0	Citizen of What Co		
	23a o	ai Di	11310 Sherrington Court 20	0774	_	J.S.A.	artity.	
215-0036	n 72 hours after death with the Maryland "naturel", or Items 23e or 28e-1 show edical Exeminat mai be notified at	by Funeral	3 XWidowed 4 ☐ Divorced If Yes, Give 1 ☐ Yes	dent of Hispanic Origin? (Sp cify Cuban, Mexican, Puerto 2 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: W		
Ų.	72 nat	eted	15. Decedent's Education 16a. Decedent's Usua (Specify only highest grade completed) (Give kind of wo	al Occupation rk done during most of work	16b.	Kind of Business/l	Industry	
Z	within ene. than "	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	se retired)	ing	0 11		
N D	filed v Hygie other t	e Co		19 Mothor's Nam	e (First, Middle, Maide	Own Hom	e	
au	d is d	To Be	C11 T.D. II 11 11	Ethe1	Georgia		ker	
lary	2 should and Men Is marke aumatic			(Street and Number or Rura	al Route Number, City	or Town, State, Z	ip Code)	
e, ≥	1 and Health em 27 other tr		Donna Swanson/ Daughter 5828 Choke				s, CO 80919	
_	Peges 1 nent of H int: If Ite iry or ot		20a. Method of Disposition 1 💆 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Nancemetery, cematory or of Mary Land Vot to a complete of the state of Disposition (Nancemeter), cematory or of Disposition (Nancemeter), cematory or of Disposition (Nancemeter), cematory or of Disposition (Nancemeter), cematory or of Disposition (Nancemeter), cematory or of Disposition (Nancemeter), cematory or of Disposition (Nancemeter), cematory or of Disposition (Nancemeter), cematory or of Disposition (Nancemeter), cematory or of Disposition (Nancemeter), cematory or of Disposition (Nancemeter), cematory or of Disposition (Nance	ther place) 3/8/	200. t 2004 Che	Location - City or 1 1tenham,	Fown, State	
Saltimor	permit. Pege Department of Important: If any injury or once.		'4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and	ans ery		Mary	land	
Ö	Depa Impo any ir once	J,		^{d Address of Facility} Rob Annapolis Roa				
П	4		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line.			maryranu	Approximate	
	Physician		Immediate Cause (Final disease or condition				Interval Between Onset and Death	
	/Medical Examiner		Due to (or as a consequence of):					
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	ficate be executed physician and s the burial-transit	Examiner	cause. Enter Underlying Cause (Lisease or in jury that initiated events c.			ī		
oo,	be exe	E	resulting in death) Last Due to (or as a consequence of):					
00/00	physics the street	edicai	d					
5	n certii anding use a	N/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of deliv	verv	
	The law requires that the death certificate be executed tie has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/M	in the past 12 months? 1 Yes 2 No 9 Unknown 1 Live birth 2 Fetal death 3 Ectopic pre 4 Pregnant at time of death 5 Other (spe			Month	Day Year	
i co	sw requires that s been signed to should be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying ca	iuse given in Part I.	23e. Did tobacco 1 ☐ Yes 2		the cause of death?	
ט ט	has be ge 2 sho	Completed	Metabolic acidoris		24a. Was an	24b. Were auto	opsy findings available	
	: The cate h	5	Acute Respiratory Failure		autopsy performed? 1 ☐ Yes 2 ☐ No	death?	ompletion of cause of 2 No	
) I	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death				
5	Phys or this oral dii	٦. <u>ح</u>	27. Manner of Death 28a. Date of Injury 28b. Time of 28		ne 5 Residence		(y)	
5	nding l ath. r: After	atio	Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation M	Work? 1 ☐ Yes 2 ☐ No	100 B000 100 1100 11110	y occurred		
	al or Atter after de I Diracto d in by th	Certification	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, building, etc. (Specify)	office 2	18f. Location (Street ar City or Town, State	nd Number or Rura 3)	al Route Number,	
		edical (29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred a 2 Medical Examiner: On the basis of examination and/or investigation, and manner stated.	t the time, date and place, a in my opinion, death occurre	and due to the cause(s)) and manner as s d place, and due to	tated. o the cause(s)	
	To th To th c mp	Me		License number	29d. Da	te signed (Month,	Day, Year)	
			Min 4 MD	72218	1 3	2/1/0	9	
			30. Name an., address of person — mpleted cause of death (Item 23a) ype, Print)	N 1 7	11/1	TIC	, (
	Stat		31. Date filed (Month, Day, Year) 32. Signature	13.00	Thede	cal.	ent r	
	Registra		MAR 0 2 2004	,				

State of Maryland / Department of Health and Mental Hygiene 1004 08815 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** March Dorothy E. Winner 30P /Medical 3007 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CUMBERLAND DILLEGAN HOSPITAL SACRED HEART If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sex **Funeral** Birthplece (State or Foreign Country) Days 1 □ M 2 1 F Director 214-07-6059 06-Jan-1916 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show item 27 is marked other than "natural", or items 23a or 28e-f show other traumatic event, the Mcdical Examinar must be notified at 1 Yes 2 □ No Director Maryland Allegany Mount Savage 10e. Street and Number 15613 Mile Lane, N.W. 10f. Zip Code 10g. Citizen of What Country? 21545death by Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 20 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black White etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify. 3 Widowed 4 □ Divorced White 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Senior Citizen's Center permit. Pages 1 and 2 should be filed Department of Health and Mental Hygin Important: if item 27 is marked other any injury or other traumatic svent, II 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 James Wharton Mary Blank 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13728 Exline Road daughter **Darlene Geary** Hancock Maryland 21750-20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) **Cumberland Crematory** 02-Mar-2004 Cumberland Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 0 100 bohn I Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lim. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Oda. /Medical Due to (or as a conseque ace of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a conseque Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of) P.O. Box 68760 the attending physician Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No detached 9 Unknown 9 Unknown signed by Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, by 90 2 No 3 Probably 4 Unknown Completed should peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has autopsy 201 No this certificate 1 ☐ Yes To the Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 20No 1 Inpatient 2 2 ER/Outpatient 3□ DOA funeral 27. Magner of Death ate of Injury (Month, Day Year) 28b. Time of Injury 28a 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 1 Natural 5 Pending investigation death. 2 Accident 2 🗌 No within 24 hours after death To the Funaral Diractor: completely filled in by the in by the 6 Could not be determined 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifie Medical and manner stated. 29b. Signature and title of certifier 29c. License number 12 Kan Vilt. Kan 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TIRS 517 Old town Koad Cumberland, NOD 21502 Nagarathan Kanzithan 31. Date filed (Month, Day, Year) State MAR 0 3 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene? [] [] [] 08816 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician Day JANE WARD 3, 11:55 PM MARCH 2004 /Medical 4c. County of Deeth 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner THE COUNTRY HOUSE **CUMBERLAND** ALLEGANY If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth Month, Day, Year JUNE 12, 1924 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🖾 F 79 218-12-5201 MARYLAND Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location ir than "natural", or Items 23a or 28a-f show the Medical Exemple: must be notified at 10d. Inside City Limits MD ALLEGANY CUMBERLAND 1X Yes 2□No Be Completed by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 U.S.A. 15 CUMBERLAND STREET filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ki No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry CELANESE FIBERS Elementary/Secondary (0-12) College (1-4or 5+) CORPORATION OFFICE CLERK other 7 is marked other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be fill timent of Health and Mental H tant: If Item 27 is marked out jury or other traumatic even PETER LOUIS WARD CECELIA JOSEPHINE KEAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) J. EDWARD ROWLEY / NEPHEW 11808 CANFIELD ROAD, POTOMAC, MD 20854 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State permit. Page Department o Important: If any injury or once. ST. PATRICK'S CEMETERY 03/09/2004 CUMBERLAND, MD * 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Livensee 22. Name and Address of Facility
UPCHURCH FUNERAL HOME, P.A.
202 GREENE STREET, CUMBERLAND, ex helle 21502 23a. Part1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Zhelmer Physician 4800 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760. attending physician Completed by Physician/Medical be detached for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of deeth 5 Other (specify) Division of Vital Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy this certificate 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 5135 30. Name and address of person who completed cause death (Item 23a) (Type, Print) Godfredans Galle Lowas

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year) NIAR 0 5 2004

ORIGINAL

32. Begistrar's Signature

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

Division of Vital Records, P.O. Box 68760,

	- State Registrar			Cert	ificate of	Death		Reg. No).		
	1. Decedent's Name (First, Middle, L	ast)					2. Date of D			3. Time of Death	
an	Myrtle	Lewi	S	Yate	a.s		Feb.	29 L	2004 ^{Year}	9:55pM	
al	4a. Facility Name (If not institution, g			1400		or Location of De			. County of Death		
er	Randolf Hills			ter	Wheat		uui	1	Montgon		
	5. Social Security Number 6. 230 – 05 – 8830	.Sex 7. 1 □ M 2 🖾 F	Age (In yrs. 90	last birthday) Yrs.	If Under 1 Year Months Days	onths Days Hours Min. (Month, Day, Year) Co					
-	Usual Residence of Decedent					1	3/22	,	3 1 1 1	rginia	
	10a. State 10b. County		10c. Cit	y, Town or Loc	ation	10d. Inside City Limits					
tor	Md Montgo	mery	W]	heaton						1 ☐ Yes 2 No	
i Director	10e. Street and Number 3524 Edwin S	treet			10f. Zip Code 2090	10g. Citizen of What Country? USA					
Completed by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decede Armed Force 1 Tyes 2 If Yes, Give Year or Date	es? ∑ iNo	r in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify:					14. Race - American Indian, Black, White, etc. Specify: White		
heren	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)	Education grade completed) College (1-4	or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)					(ind of Business/li	ndustry	
E	8	College (194	01 5+)	Wa	aitress	;	Re	estaura	int		
Bec	17. Father's Name (First, Middle, La	st)		'			ame (First, Middi		Sumame)		
0	James Lewis					Mary	Wood	ly			
10a. State 10b. County 10c. City, Town or Location 10c. City 1											
	20a. Method of Disposition	., .,	20h. P	1000			Date		ocation - City or T		
	1 ABurial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec				tion (Name of story or other pla Church		/04/04		Dry For		
21. Signatule of Funeral Service Licenstee PHILIP D.RINALDI FUNERAL SERV 9241 Columbia Blvd.Silver Spi 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,											
	23a. Pert1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition	ly one cause on eac	h line.		the mode of dyi		ac or respiratory	arrest,		Approximate Interval Between Onset and Death Years	
H	resulting in death)		as a consequ		rsease					years	
iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uissass or injury	b. Due to (or	as a consequ	uence of):			=======================================				
Examiner	that initiated events resulting in death) Last	c. Due to (or	as a conseq	uence of):							
n/Medical E		d									
edi										China Charles appare	
by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		h 2 ∏Fetai nt at time of d	Ideath 3 □E	Ectopic pregnanc Other (specify) _	у			23d. Date of deliv Month	rery Day Year	
l by Pt	Part II. Other significant conditions chronic obst			=		ven in Part I.				the cause of death?	
ompieted	_senile_inanii			<u>urbour</u>			24a. Wa		24b. Were auto	opsy findings available ompletion of cause of	
1 0											
Be	25. Was case referred to medical examiner?	Hamitali			0.4		eath (Check only				
P.	1 ☐ Yes 2X No	Hospital: 1 🗆 Inp	atient 2 🗆	ER/Outpatient	3□ DOA O	ner: 4 🖾 Nursing	Home 5 ☐ Res	idence (6 □Other (Speci	fy)	
Certification:	27. Manner of Death 1 XNatural 5 Pending 2 Accident investigat	ion	Injury Day Year)	28b. Time of Injury	28c. Inju Wo M 1	ryat rk?]Yes 2 ☐ No	28d. Describe	how injur	ry occurred		
Sertific	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	ad 286. Place of	Injury - At ho , etc. (Specify	ome, farm, stree	eet, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State)						
Medical C		Physicien: To the be eminer: On the bas and manne	is of examina								
Me	29b. Signature and title of certifier		_		29c. Licens	se number		29d. Dat	te signed (Month,	Day, Year)	
	Martin - Shends				DO	8944		3/01/04			

State

Registrar

3720

32. Registrar's Signature

Farragut Ave. Kensington, Md

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Martin Shargel
31. Date filed (Month, Day, Year)

MAR 0 4 2004

	1 For State Registrar	of Maryland / Dep. <i>Ce</i>	artment of Health a <i>rtificate of Death</i>		ene 2004 08811
Physician	1. Decedent's Neme (First, Middle, Last)			2. Date of Death Month	Day Year 3. Time of Death
/Medical Examiner	Martin F. Zercoe 4a. Fecility Name (If not institution, give street and n	umber)	4b. City, Town, or Location of	February	7 19, 2004 11:46 A ^M
Ladillilei	Anne Arundel Medical		Annapoli	.s	Anne Arundel
Funeral Director	5. Social Security Number 6. Sex 1 ☑ M 2 ☐ F	7. Age (In yrs. last birthday) Yrs.	If Under 1 Year If Under 2 Months Days Hours 1	4 Hrs. 8. Date of Birth (Month, Day, Y	
D .	Usuel Residence of Decedent 10a. State 10b. County	10c City Town as I			
ahov elent	10a. State 10b. County Maryland Anne Arundel	10c. City, Town or Lo	Arnold		10d. Inside City Limits 1 ☐ Yes 2 ☒ No
r 28a-f ehow routiled at	10e. Street and Number		10f. Zip Code	100	. Citizen of What Country?
death with the Maryland ms 23e or 28e-f ehow finish be rediffed at neral Director	1407 Mariner Drive		21012		U.S.A.
ir, or its	Armed	3 2 XX No Give	Was Decedent of Hispanic Orig If Yes, specify Cuban, Mexican, 1 ☐ Yes 2☒ No Specify:	in? (Specify Yes or No- Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
_ Tall	15. Decedent's Education (Specify only highest grade completed Elementary/Secondary (0-12) College	d) (Give	dent's Usual Occupation kind of work done during most DO NOT use retired)	of working	bb. Kind of Business/Industry
Mental Hygarked otheratic event,	17. Father's Name (First, Middle, Last) Gregory Zercoe		-	's Name (First, Middle, Ma tina Grothee	
should and Men s marks umatic	19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Street and Number	or Rural Route Number, C	City or Town, State, Zip Code)
and 2 ealth a n 27 is	Martina Zercoe/mother		7 Mariner Drive		21012
permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than eny injury or other traumatic event, Item since. To Be Comp	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	Baltimon	matory or other place) re Crematory	3/4/2004 E	c. Location - City or Town, State Baltimore, MD
permit. Departimport. eny inj.	21. Signal Funeral Service Lice see				rlor Funeral Home unnapolis, MD 21401
179	23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on	t caused the death. Do not en each line.	ter the mode of dying, such as o	ardiac or respiratory arres	Interval Between
Physician	Immediate Cause (Final disease or condition	elmonary &	Typoplasia		Onset and Death One hour
/Medical Examiner	resulting in death) Due to	o (or as a consequence of):	1		0 /
e -	Sequentially list conditions, if any, leading to immediate	o (or as a consequence of):	typoplasia drome		The hom
physician and s the buriat-transit	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Re	nal Ago (or as a consequence of)	enesis		One how
	d				
The law requires that the death certifuction in the has been signed by the attending page 2 should be detached for use as capped by Physician/Me:	in the past 12 months?	gnant at time of death 5	☐Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year
that the hold by detac	Part II. Other significant conditions contributing to	cco use contribute to the cause of death?			
w requires that been signed to should be delta should be delta ifeted by PI				1 🗆 Yes	2 No 3 Probably 4 Unknown
The law required that has been spage 2 should				24a. Was an autopsy performe	
	25. Was case referred to medical examiner?		26. Place	1 ☐ Yes 2 ½ of Death (Check only one)	No 1 ☐ Yes 2 ☐ No
S d	1 ☐ Yes 2 No Hospital: 15	Inpatient 2 ER/Outpatie		sing Home 5 Residence	ce 6 Other (Specify)
g fee	1 Natural 5 Pending (Mc 2 Accident investigation	e of Injury 28b. Time onth, Day Year) Injury	of 28c. Injury at Work? M 1 Yes 2 N	28d. Describe how	injury occurred
P E Dist	3 Suicide 6 Could not be 4 Homicide determined buil	ce of Injury - At home, farm, st Iding, etc. (Specify)	reet, factory, office	28f. Location (Stree City or Town,	et and Number or Rural Route Number, State)
ne Hospital n 24 hours a se Funeral bletely filled	(Check only 2 Medical Examiner: On the	he best of my knowledge, deat basis of examination and/or in anner stated.	th occurred at the time, date and investigation, in my opinion, death	place, and due to the cause occurred at the time, date	se(s) and manner as stated. e and place, and due to the cause(s)
To the vithin 2 To the complete	29b. Signature and title of certifier		29c. License number	0	Date signed (Month, Day, Year)
	Jy Lino		D4715	8 Te	mary 25, 2004
	Yann-Yann L	use of death (Item 23a) (Type,	Print) 2001 Medical P		polis, MD 21401
State Registrar	31. Date filed (Mońth, Day, Year) 32. MAR 0 3 2004	Registrar's Signature	book		

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			State of Marylan	•	nt of Health and <i>te of Death</i>		20	101	00016
	-	1. Decedent's Name (First, Middle, Las	at)	Certifica	le oi Dealii	2. Date of Deet	eg. No. 🔼 🕻	104	3. Time of Death
	sician	Ann	Anderso	n		Month	Day	Yeer	3 25 PM
1	edical miner	4a Facility Name (If not institution, give		//	4b. City, Town, o	r Location of Deeth	4c. County	27	0 401111
LAU.	IIIICI	Aunshurg Lu	thepan H	lone	PAITI	MORE			
Fune	al	Social Security Number 6. S		lest birthdey) If Under	or 1 Year If Under 24 Hr	s. 8. Date of Birth	Year) /	9. Birthpla	ace (State or Foreign
Direct	or	214-100107	□M 2¶F }	Yrs.	Days Flours Will	9-1-1	1914	Mar	uland
pue >		Usuel Residence of Decedent 10a. State 10b. County	10c Cit	y, Town or Location				10	d. Inside City Limits
1020 Journal after death with the Marylen ral; or items 23s or 28s-f show Examinant reasts be notified at	ō	100			0 :			10	1 □ Yes 2 No
the N	Funeral Director	10e. Street end Number	10.66	BALTI	p Code	11	0g. Citizen of V	What Countr	-
with or	ā	2/4// Casishi	1.6	101. 2.	21234	,	og. Ottizen or v	SA	y:
death	era	11. Marital Status	12. Was Decedent Ever in U.	,S. 13. Was Dece	edent of Hispanic Origin? (ecify Cuban, Mexican, Pue	Specify Yes or No-	14. Rac	e - America	n Indian,
or the	Ē	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 1 No		1.7	rto Rican, etc.)	Blac	k, White, et	C.
002 ours	by	3 Widowed 4 □ Divorced	If Yes, Give A Year or Dates:	1 ☐ Yes	2 No Specify:		Specify	Whi	te.
21215-0020 d within 72 hours after death with the Maryland glene. The neutral, or frems 23s or 28s-f show the Medical Examiner mast be notified at	Completed by	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a. Decedent's Usu (Give kind of w	ork done durina most of w	orking	16b. Kind of Bu	ısiness/Indu	stry
vithin ene.	E I	Elementary/Secondery (0-12)	College (1-4or 5+)	life. DO NOT	ise retired)		P		P-1.6.
d 2 filed v filed v filed v	ပိ	17. Father's Neme (First, Middle, Last)		Office a	OOKKOK .	ame (First, Middle, A	DALTI	MORE	ECITY COVI
ylan ould be wented or	Be	11) 1/10 ha	Kado		A o	in a Ro	10013011011	-	/
ire, Maryland 21215-0 s 1 and 2 should be filed within 72 he theath and Mental Hygiene. Item 71 is marked other than 'netur other traumatic event, the Madical	2	19a. Informant's Name/Relationship (7	vpe Print)	19b. Mailing Addres	s (Street and Number or F	Burel Boute Number	City or Town	State Zin C	Code)
and 2 seath ar n 27 is		TOO KENET	_	2/0/5/	reighton A	UP RAIT	MARE	MA	21234
of Hear		20a. Method of Disposition		Place of Disposition (Na emetery, crematory or	me of	Date	20c. Location -	City or Tow	n, State
Peges nent of line. If the lay or o		1 Burial 2 Cremetion 3 4 Donation 5 Other (Specify	nemoval from State	LKWOOD C		3-23-04	DADVII	111=	ms
arte arte	9	21. Signature of Funeral Service Licens		22. Name a	nd Address of Facility 8	M HARFO	PN RI	ille,	71731
De ge in	ä	Level 10 1	Zaul to	5/40				/	21234.
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the death	n. Do not enter the mo	DENTE de of dying, such as cardia	ac or respiratory arre	BALT.	P	Approximate
Physicia	n	shock, or heart failure. List only o						i li	nterval Between Onset and Death
/Medic	al	Immediate Cause (Final disease or condition	ATHEROSCI	TROTIC	CEREBA	O VASCI	ILAR	1)102	TACI
Examin		resulting in death)	-	r as a consequence of)				100	,,,,,
J. B. F	Examiner		b						
58760, cate be axecuted physician end sthe buriel-transit	xarr	Sequentially list conditions, if any, leading to immediate	Due to (or	r es e consequence of)				1	
68760, licate ba axi physician es the buriel.	calE	cause. Enter Underlying Cause (Disease or injury	C						
0 4	윭	that initiated events resulting in death) Lest	Due to (or	es a consequence of):				1	
	N.		d		-4				
Box laath cert ettending for use	Physician/M	Death Other designation and the				T		. !	
O a typ	hys	Part II. Other significant conditions co		itting in the underlying o	ause given in Part I.				he cause of death?
S, P as that igned t be det	by P	HYPOTHEROI	DISM			I L Ye	s 2□No	3 Proba	bly 4 Unknown
Records, P he law requiras that e has been signed b aga 2 should be deta						24a. Was an	autopsy		autopsy findings
law relas bee	Completed		*			perform	100 /	comp of de	able prior to pletion of cause eath?
I Re(The law ete has paga 2	E					1 □ Ye	s 2DNo	10	Yes 2 No
	Be	25. Was case referred to medical			26. Place of De	eath (Check only one			
G 0 2	ם	examiner?	Hospital: 1 ☐ Inpatient 2 ☐ I	ER/Outpatient 3 Di	Other:	Home 5□ Resider		or (Specify)	
n o PP Her th meral		27. Menner of Deeth j1 ☑ Natural 5 ☐ Pending	28e. Dete of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how	w injury occurre	∍d	
Division or Attending after death. Director: Attending	Certification:	2 ☐ Accident investigation		M	1 ☐ Yes 2 ☐ No				
or Att after d Direct in by	i i	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Plece of Injury - At ho building, etc. (Specify	me, farm, street, factor	y, office	28f. Location (Str. City or Town,		er or Rurel F	loute Number,
Division Of To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After this completely filled in by the tuneral	ပိ								
Hospital 24 hours Funeral I	edical	Check only 2 Medical Exami	sician: To the best of my knowner: On the basis of examinati	vledge, death occurred ion end/or investigation	at the time, date end place, in my opinion, death occ	e, end due to the car urred at the time, da	use(s) and mar te and place, a	nner as statender as at a	ed. ne cause(s)
To the within 2 To the	Mec	one) 29b. Signature and title of certifier	end manner stated.		c. License number		d. Date signed		
or vert	_	1	Janna	23) gorer-	- 29	2/10	1 NT	y, rour,
		Jaserem 200	The state of the s	02a) /Time Diati	17 87 77		2/17/	109	
Tt		30. Name and address of person who co	HAW, 722		HEIGHTS 1	AVE B	Aero	MA	91208
	tate		3. Registrer's Signat		. 1 9 . 113 /	1,- 1,0	., , -		
, ,	strar	31. Date filed (Month Day, Year)	Bearing 12	Buch .					

04-1827			State of Marylan			-	_			
AKG		1 - Stote unpend item#23a,F	art II, 27,28a-f	,Per ME, C830	te 3/068th		Reg. No. 200	14 08821		
Physic	ion	1. Decedent's Name (First, Middle, Last)	1			2. Date of D Month	Day Yea			
Physic /Medi	cal	Arvine	Angerso) n	y, Town, or Location of De		4c. County of De	7:55 A ^M		
Exami	ner	4a. Fecility Name (If not institution, give state 4601 PALL MALL RC			timore	201	\/ /	Ä		
Funeral		5. Social Security Number 6. Sec	7. Age (In yrs.	last birthday) If Und	ler 1 Year If Under 24 H		rth 9: B	hirthplace (State or Foreign Country)		
Director		214-56-8803 19 Usual Residence of Decedent	M 20 F 51	Yrs.		June	29,1952	Maryland		
/land		10a. State 10b. County	10c. Cit	y, Town or Location				10d. Inside City Limits		
e Man	ctor	Maryland NIA		Baltim	ore			1 Yes 2 No		
1215-0036 within 72 hours after death with the Maryland ene. than "natural", or Hems 23a or 28a-f show the Modical Exemites must be notilised at	Funeral Director	10e. Sifeet and Number	DJ	10f_2	Zip Code		10g. Citizen of What (Country?		
seath v	eral	11. Marital Status	12. Was Decedent Ever in U	.S. 13. Was Dec	cedent of Hispanic Origin?	(Specify Yes or N		nencan Indian,		
after of ter	Fun	1 Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 10 No If Yes, Give		pecify Cuban, Mexican, Put 2 No Specify:	эпо нісап, етс.)	Specify: 1	hite, etc.		
21215-0036 glawithin 72 hours af giene. er than "natural", or tha Modical Exerci-	d by	3 Widowed 4 Divorced	Year or Dates:	16a. Decedent's Us			16b. Kind of Busines	SIACK		
15-	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed) College (1-4or 5+)	(Give kind of the DO NOT	work done during most of w	rorking	100. Kind of Busines	, 1 ·		
d 212 filled with Hygiene ther the	Com	Elementary/Secondary (0-12)	(1-46/34)	Lab	orer		Cons	ruction		
be filed training the filed training tr	Be	17. Father's Name (First, Middle, Last)	1-10-	/	18. Mother's N	ame (First, Middle	e, Maiden Surname)			
Maryland nd 2 should be file th and Mental Hy 77 is marked oth	2	19a. Informant's Name/Relationship (Ty	pe. Print day obter	19b. Mailing Addre	ess (Street and Number or	Rural Route Numi	ber, City or Town, State	, Zip Code) 20904		
and 2 s and 2 s ealth ar m 27 is		Mrs Rhonda E	Brown	2006 H	larlequini	Errace	Silvers	pring, Md.		
of Hear		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F		Place of Disposition (A cemetery, crematory of	lame of rother place)	Date	20c. Location - City	or Town, State		
Baltimore, Maryland 21215-0036 sermit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 ie marked other than "natural", or items 23a or 28a-f ehow my highry or other traumetic event, the Madical Examinar must be notified at once.		* 4 □Donation 5 □ Other (Specify)		It. Car	mel	-4004	Dunda	CIK, IVId.		
Balt permit. Depart Imports eny inju		21. Signature of Funeral Service/Licens	J. Russ	1/ Josep	and Address of Facility	Funes	al Home	212.16		
		23a. Part 1 Enter the disease, or compleshock, or heart failure. List only or	ications that caused the deat	th. Do not enter the m	ode of dying, such as card	ac or respiratory	arrest,	Approximate Interval Between		
Physician		Immediate Cause (Final disease or condition	Seizure Disor	der				Onset and Death		
/Medical Examiner		resulting in death)	Due to (or as a conseq	quence of):						
		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseq	quence of):						
cuted	Examiner	that initiated events	c							
760, te be executed ysicien and e burial-transit		resulting in death) Last	Due to (or as a conseq	quence of):						
6876 ifficate b ig physic as the b	dlcal		d							
P.O. BOX 687 that the death certificate ed by the attending phys detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna		pregnancy		23d. Date of o	•		
O. B. Geath	sicla	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 Feta 4 Pregnant at time of c 9 Unknown				Month	Day Year		
ords, P.O. requires that the d	Phy	9 Unknown Part II, Other significant conditions co	ntributing to death but not res	sulting in the underlyin	g cause given in Part I.	23e. Did	tobacco use contribute	to the cause of death?		
Division of Vital Records, P to or Attending Physician: The law requires tha atter death. Director: Alter this certificate has been signed to by the funeral director, page 2 should be detailed.	d by	Closed Head Injury wit				1 🗆	Yes 2 No 3	Probably 4 🗷 Inknown		
aw req	Completed					24a. Wa	s an 24b. Were	autopsy findings available o completion of cause of		
I Rec	Com					per	ormed? death	?		
of Vital F Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Other	eath (Check only		A+ ccopo		
Of Phys	To To	1 X Yes 2 No 27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Injury at Work?	Home 5 Res	how injury occurred	pecify) At scene		
Vision Attending r death. ector: After	atlor	1 Natural 5 Pending 2 Accident investigation	unknown	unknown M	Work? 1 ☐ Yes 2 ♣ No	unknown				
iviscio	ertification:	3 ☐ Suicide 6 ♣ Could not be determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, street, fact fy)	tory, office	City or To	(Street and Number or own, State)	Rural Route Number,		
Division of To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	O	O Contract the Con								
ne Hos n 24 h ne Fur pletely	edical	(Check only 2 Medical Example)	iner: On the basis of examina and manner stated.	ation and/or investigati	ion, in my opinion, death or	curred at the time	, date and place, and d	ue to the cause(s)		
To the within 2: To the I	Σ	29b. Signature and title of certifier	*	:	29c. License number		29d. Date signed (Mo			
7		P Chrest		- 00-1 07 - 5	O.C.M.E.		March 14,	, 2004		
		30. Name and address of person who c	UBIO, M		Penn Street	, Baltim	ore, Maryla	and 21201		
	ate	31. Date filed (Month, Day, Year)	32. Registrar's Sign	ature			-			
Regis	trar	MAR 1 9 2004	To get a	9 Sport	1/2/					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 08821 For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) March 16^{Pay} 2004^{ear} **Physician** Shirley Α. Abbott 8:15 P /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner 8415 Bellona Lane #903 Towson Baltimore 8. Date of Birth (Month, Day, Year) Feb. 04, 1937 If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. Birthplece (State or Foreign Country)
 Maryland 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months **Funeral** 1 ☐ M 2 🗙 F 212-34-7346 67 Director Usuel Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 28a-1 show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Director Baltimore Md. Towson 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ò 8415 Bellona Lane #903 21204 USA "natural", or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. I hoperate if item 27 is marked other than "naturelt, or item any injury or other traumatic event 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 💆 No Baltimore, Maryland 21215-0036 White Specify. 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) +4 Freelance Writer Writing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frederick P. Streb Mildred Buck 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3904 Sweet Air Rd. Phoenix, Md. 21131 Sherie Harrison/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ★ Burial 2 Cremation 3 Removal from State Dulaney Valley Mem. 3-19-04 Timonium, Md. 4 ☐ Donation 5 ☐ Other (Specify) ^{22. Name and Address of Facility} uneral Home, 1050 York Rd. Towson, Md. 21. Signature of Funeral/Service 23a. Part 1. Enter the disease, oxcomplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition a Arteriosclosotic Condiovascular Enysician 5 years resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical as the IF FEMALE esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death jo in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) een signed by the a hould be detached t 1 ☐ Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 ad bluod 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔏 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an certificate has page 2 1 Yes 2 No 2**0** No or Attending Physician: funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes 2 □ No 2 ER/Outpatient 3□ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After Injury 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and file of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date flied (Month, Day, Year) MAR 1 9 2004



who completed cause of death (Item 23a) (Type, Print)

018667

March 17, 2004

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 5 per State of Maryland (Bepartment of Health and Mental Hygiene 2004 08822 For A State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day **Physician** Mary Virginia Allen 10:55P 04 03 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Harbor Hospital Center Baltimore MD N/A 7. Age (In yrs. last birthday) 86 Yrs. Social Security Number 15 09 3237 214-18-7480 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours Min 1 M 2 DE Yrs. 07/23/1917 TT Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD N/A Baltimore City Director XXYes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1468 Reynolds Street 21230 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black. White, etc. 1 Never Married 2 Married 1 ☐ Yes **2CX**No Specify: Completed by 3€XWidowed 4 □ Divorced Specity: white Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 O Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Bruce Casterline Hazel Jones 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Howard S. Allen, Jr. / Son 3701 Whitehall Lane, Hampstead MD 21074 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Cedar Hill Cem. 1 XX urial 2 ☐ Cremation 3 ☐ Removal from State 03/18/2004 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Euneral Secrice Licensee Victor P. Doda, Jr. 22. Name and Address of Facility
Charles L. Stevens Funeral Home, Inc. 1501 Fast Fort Avenue, Baltimore MD 21230 hat baused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, a of bach line. 23a. Part1. Enter the disease, or complications shock, or heart failure. List only one cause Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition CYER resulting in death) Due to (or as a consequence of): eriosclerotic Cardiovamentar disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner (or as a consequence of): Due to (or as a consequence of): Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an 1 Yes 2 X No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Exactifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

that the death certificate be executed Division of Vital Records, P.O. Box 68760, The law requires Physicien: or Attending within 24 hours a To the Funerel D the Hospitel

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or Items 23a or 28a-1 show empty injury or other traumetic event, the Madical Examiner must be notified at once.

Physician

/Medical

Examiner

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page certificate

Maryland 21215-0036

Baltimore,

State Registrar

29b. Signa and attle of certifier

30. Na and address of person who con

31. Date filed Month, Day, Year)
MAR 1 9 2004

DHMH 17 Rev 1/2001

216 Years

pleted cause of eath (Ite 23a) (Type, Print)

MO 32 F egistrar's Signature

10

29c. License number

126203

1319 Light St. Baltimore MO

29d. Date signed (Month, Day, Year)

3/15/04

Registrar

MAR 1 9 2004

			1 - For State Registrar	State of	Marylan		artment of I		d Mental Hy	giene Reg. No. 20	n ()	00001
			Decedent's Name (First, Middle, L.	ast)	····			200	2. Date of De	eath	04	3. Time of Death
	Physic /Medi		Chin-Hui			Boyk	ins		March	16 20	Year 004	12:12 p M
	Exami		4a. Facility Name (If not institution, g		,		4b. City, Town,	or Location of D	eath	4c. County		, F
			Anne Arundel Me							Anne	Arui	ndel
	Funeral Director		5. Social Security Number 6. 579–78–6281	Sex 7. 1 ☐ M 2 X F	. Age (In yrs. 62	last birthday) Yrs.	If Under 1 Year Months Days		Vin. (Month, Da	ay, Year)	9. Birthp	lace (State or Foreign try)
			Usual Residence of Decedent		02				March	11,1942	Sout	th Korea
	nylanc how		10a. State 10b. County		10c. Cit	y, Town or Lo	cation				1	0d. Inside City Limits
	e Ma Sa-f a	Director	MD Anne A1	undel	Ha	rwood						1 ☐ Yes 2XXVo
	or 24	Dire	10e. Street and Number				10f. Zip Code			10g. Citizen of \	What Coun	itry?
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926	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f ahow any injury or other traumatic event. It wellcal Examinat must be notified at once.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Deceded Armed Force 1 Test 2 If Yes, Give Year or Date	es?		Was Decedent of t f Yes, specify Cub 1 ☐ Yes XXNo		? (Specify Yes or No uerto Rican, etc.)		e - Americ ck, White, o	etc.
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Ma	id 2 s lith an 27 is i		Robert A. Boyki		\ L							
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Ë	Page: ent o nt: #		1 X Burial 2 ☐ Cremation 3 3 4 ☐ Donation 5 ☐ Other (Spec		a.o			1	/20/2004		•	
Baltimore,	permit. Departm Importa any inju		21. Signature of Funeral Service 100		1241		Name and Addre Hardesty	ess of Facility Funera	al Home, 1	P.A.		
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	Physician /Medical Examiner		shock, or heart failure. List ont Immediate Cause (Final disease or condition resulting in death)	a	D.	umor	۴					Interval Between Onset and Death
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	To the Hospital or Attend within 24 hours after death To the Funeral Director; completely filled in by the	fedical	one) 2 Medical Exa	nysician: To the be miner: On the basis and manner	s of examinati	vledge, death on and/or inv	occurred at the tir estigation, in my o	ne, date and pla pinion, death oc	ace, and due to the occurred at the time, o	cause(s) and man date and place, a	nner as sta nd due to t	ted. he cause(s)
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should and Men amarke numatic		19a. Informant's Name/Relationship (Typ	oe, Print)	19b. Mailin	ng Address (Street	and Number or R	ural Route Numb	er, City or To	own, State, Zip	Code)
- X = N -		NINA PHILLIPS (DAUG			W. LANVAL		BALTIMOR			
3 6 0	1	20a. Method of Disposition 1 ☐ Surial 2 ☐ Cremation 3 ☐ Re * 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	cemetery, crei	sition (Name of natory or other plac IAL PK	3/20/	Date /04		ion - City or To	own, State
permit. Pego Depertment Important: If eny injury o		21. Signature of Funeral Service License	7		2. Name and Address 638 N. GILM		LIE FUNERA BALTIMORI			
Physician /Medical		23a. Part1. Enter the disease, or complications, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each line.	cancer		g, such as cardia	c or respiratory a	rrest,		Approximate Interval Between Onset and Death
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2 2 2 2	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of print 1 Live birth 2 1 4 Pregnant at time 9 Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	,		230	I. Date of deliv Month	ery Day Year
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iclen: Th	De l	25. Was case referred to medical examiner?			Otto	00	ath (Check only			
Jing Phy Jing Phy After this funeral d	tion: 10	27. Manner of Death	ospital: 1 Inpatient 28a. Date of Injury (Month, Day Yea	2 ER/Outpatien 28b. Time o Injury	f 28c. Injur	4 Li Nursing	Home 5 Resi			(y)
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	7	> Valu	au 1	11)	1520				ch,15,	
9		30. Name and address of person who co	an uni	versity	of Mar	yland	Hospit	al	Balt	imore, MD
State Registra		31. Date filed (Month, Day, Year) MAR 1 9 2004	32 Registrar's S	Signature	1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1					

04-1904 B.K.S TIMOTHY LEE BRUNSON

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2004 0882
State of Maryland / Bopartmont of Hoalth and Montar Hygicile 2 0 0 0
State of Maryland / Department of Health and Mental Hygiene

Exa Fund Direc

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural" or Items 23s or 28s-f show

Physic /Medi Exami

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and

Division of Vital Records, P.O. Box 68760,

		State Registrar		Cei	tificate of l	Death	Reg	. No. 2 U U 4	00026
		1. Decedent's Name (First, Midd	(e, Last)				2. Date of Death		3. Time of Death
ician	•	TIMOTHY LEE BRU	NSON				Month MARCH	17, 2004	0732 A M
dical		4a. Fecility Name (If not institution			4b. City. Town, or	Location of Death		4c. County of Death	
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al	1	5. Social Security Number	6. Sex 7. Ag	e (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	ear) 9. Birth	iplace (State or Foreign intry)
or	-	219-62-4523		50 Yrs.			OCT. 11,	1953 MARY	LAND
	-	Usual Residence of Decedent 10a. State 10b. County	,	10c. City, Town or Lo	cation				10d. Inside City Limits
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Director		10e. Street and Number			10f. Zip Code			. Citizen of What Cou ITED STATE	
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Funeral	-	11. Marital Status	12. Was Decedent	Ever in U.S. 13.	Vas Decedent of Hi	ispanic Origin? (Sp	ecify Yes or No-	14. Race - Amer	
		1 Never Married XX Mar	ned XXXYes 2 ☐ !	№ 1973 – '		ın, Mexican, Puerto	Hican, etc.)	Black, White	, etc.
þ		3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1981	I∐Yes XXX No	Specify:		Specify:	ACK
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C		17. Father's Name (First, Middle,	-				e (First, Middle, Ma		
100								•	
ို		GEORGE E. BRUNS		10h Mailie		JOAN E. V		ity or Town, State, Zi	in Control
		19a, Informant's Name/Relations			,				
	-	PATRICIA BRUNSO	N (WIFE)	12813 20b. Place of Dispo	FERNWOOD			ARYLAND 20	
		20a. Method of Disposition 1 ☐ Burial ————————————————————————————————————	3 □Removal from State	cemetery, cren	natory or other plac	(e)	10	c. Location - City or T	own, State
	L	14 ☐ Donation 5 ☐ Other (S	Specify)	BALTIMÓRE LOUDON 1			BA	ALTIMORE,	
	-	21. Signature of Funeral Service	Licensee	22	. Name and Address	ss of Facility LOU	DON PARK WILKENS	FUNERAL HO	OME
	J	XXM U.X.	11100gg .					ARYLAND 21	229
		23a. Inter the disease, o	r complications that caused t only one cause on each lin	the death. Do not ente	er the mode of dying	g, such as cardiac	or respiratory arrest	,	Approximate Interval Between
		Immediate Cause (Final		sclerotic C	ardiovaso	cular Dis	ease	11	Onset and Death
		disease or condition resulting in death)	a	a consequence of):					
			000 10 (01 20	2 001130quario0 01).					
i ii		Sequentially list conditions,	b. Due to (or as	a consequence of).					
Examiner		if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	<						
xar		that initiated events resulting in death) Last	Due to (or as	a consequence of):					
								1	
/Medical			d		· · · · · · · · · · · · · · · · · · ·				
ĭĕ		IF FEMALE:	23c. If ves. outcome	of					
, =		23b. Was decedent pregnant in the past 12 months?	1 Live birth	2 Fetal death 3	Ectopic pregnancy			23d. Date of deliv Month	ery Day Year
SIC		1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at 9☐ Unknown	time of death 5	Other (specify)				
Physician									
þ	•	Part II. Other significant conditi	ons contributing to death b	ut not resulting in the ur	iderlying cause give	en in Part I.		co use contribute to t	V
Pe							1 🗌 Yes	2 No 3 Pro	bably 4 Unknown
Completed							24a. Was an		opsy findings available
E							autopsy performed 1 Yes 2 1	death?	empletion of cause of
O		25. Was case referred to medica	1			26 Place of Death	(Check only one)	No 1 Yes	2 L No
o B		examiner? 1 ☑ Yes 2 ☐ No	Hospital:	nt 2 ☐ ER/Outpatien	Othe		me 5 Residenc	e e Other (Speci	AT SCENE
\Box	+	27. Manner of Death	1 ☐ Inpatie		t 3□ DOA 28c. Injury	4 Nuising no	me 5 ∐ Residenc 28d. Describe how		y) AI DOLLAD
0		XXNatural 5 ☐ Pendi		Year) Injury	Work	k? Yes 2 □ No	2001.2001.201.00	,,	
Ca		3 ☐ Suicide 6 ☐ Could	not be	un. At home form stre			39f Longtion (Street	stand Number or Cur	of Courts Number
Certification:		4 ☐ Homicide determ	building, et	ury - At home, farm, stre c. (Specify)	еет, гастогу, оптсе		City or Town, S	it and Number or Run Itale)	ar Houle Wurnber,
Sa		(Check only 2/\(\triangle \) Medical	ng Physician: To the best of Examiner: On the basis of	examination and/or inv	i occurred at the tim restigation, in my op	ie, date and place, pinion, death occurr	and due to the caus ed at the time, date	e(s) and manner as s and place, and due t	stated. o the cause(s)
Medical	-	one)	and manner sta	ited.					
1		29b. Signal and title of certifie	/ }	000	29c. License			Date signed (Month, ARCH 17.	2004
		Malin	Mon	+ Hal	0.0.		171	1/1	
,]		30. Name and address of person	who completed cause of a						William S.
1		TATRICIA +	GONICA TO	Per	n Street,	, Baltimo	re, Maryl	and 21201	
State		31. Date filed (Month, Day, Year,	30. Registra	ar's Signature					

Registrar

MAR 1 9 2004

			For State Registrar	State of	Marylan		artment of H		nd Mental Hy	giene Reg. No. 20 (14 08827
	Physicia /Medic		1. Decedent's Name (First, Middle, Lasi Shirley V. Benn						2. Date of De Month MAR	Day 14 200	4 1915 M
)	Examin		4a. Facility Name (If not institution, give St. Agnes HEA 5. Social Security Number 6. Se	LTHCAR		last hirthday)	4b. City, Town, or Baltin			4c. County of De	
	Funeral Director		213-34-1671 Usual Residence of Decedent	_M 21∆ F	6	8 Yrs.	Months Days	Hours	Min. 8. Date of Bir (Month, Da March 5	1936 Ma	iryland
	72 hours after death with the Maryland natural', or liems 23a or 28a-f show deal Eparifice must be codified at	Oirector	10a. State 10b. County Maryland Not App 10e. Street and Number			y, Town or Lo	10f. Zip Code			10g. Citizen of What	•
36	be filed within 72 hours after death with the Marylan Ital Hygiene. Id other than "natural", or liems 23a or 28a-f show event, the Medical Epaining must be rediffed at	by Funeral Director	500 Queensgate Ro 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Dece Armed For 1 Tes If Yes, Give Year or Da	ces? 2 ∰No 9		21229 Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	ispanic Origi an, Mexican, Specify:	in? (Specify Yes or No Puerto Rican, etc.)		States merican Indian, hite, etc. White
21215-0036		Completed I	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation		(Give	dent's Usual Occup kind of work done DO NOT use retired	ation during most i)	of working	16b. Kind of Busine Food Ser	
Maryland 2	should be filed within and Mental Hygiene. I marked other than umatic event, the M	To Be Co	17. Father's Name (First, Middle, Last) John Vernon Cook					Miri	's Name <i>(First, Middl</i> e am Morgan		
	nd 2 state at 27 ls r treu		Jack Benny-Husbar		20h F	500			or Rural Route Numb ad, Baltim Date		and 21229
Baltimore,	Pages nent of ant: If i		20a. Method of Disposition 1 Strial 2 □ Cremation 3 □ 1 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service) Incen)		don Pa	rk Cemete	ery Ma	arch 18, 04	Baltimore	e, Maryland
Ba	permit. Departr Importe any inju		23a. Part1. Enter the disease, or comp	fyle	SOV						rland 21229
>	Physician /Medical		shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	aiN	TRACK or as a conseq	APIAL					Interval Between Onset and Death
8760,	eate be executed hysician and the buriat-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. B f	CAIN or as a conseq or as a conseq	TUMC	PR				6 MONTHS
P.O. Box 68	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		nth 2∐ Feta antat time of o	aldeath 3[□Ectopic pregnancy	′		23d. Date of Month	delivery Day Year
	quires that in signed by uld be deta	þ	Part II. Other significant conditions o	ontributing to de	ath but not res	sulting in the u	inderlying cause giv	en in Part I.			to the cause of death? Probably 4 Whitnown
Il Records,	The page	Completed							24a. Was auto perfo 1 🗌 Yes	psy prior ormed? death	autopsy findings available to completion of cause of ? es 2 \(\text{No} \)
on of Vital	ng Phys	To Be	25. Was case referred to medical examiner? 1 Yes 2 Yo 27. Manner of Death 1 Accordant investigation	28a. Date of (Mont		ER/Outpatien 28b. Time of Injury	f 28c. Injur	er: 4 🗆 Nur			pecify)
Division	To the Hospitel or Attendit within 24 hours after death. To the Funaral Director: A completely filled in by the fu	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e, Place	of Injury - At h	ome, farm, st	reet, factory, office		28f. Location (Street and Number or wn, State)	Rural Route Number,
	the Hospitel iin 24 hours a the Funaral i spletely filled	cai			isis of examina				d place, and due to the h occurred at the time,		
	To the within 2 To the complet		29b. Signature and title of certifier	MD			29c. Licens			29d. Date signed (MC 14 TIMDRE	
_	1						Print) E, 900 CA	ton A	NENUE, M) 21229,	
	Sta Regist		31. Date filed (Month, Day, Year) MAR 1 9 2004		egistrar's Sign						

				1_ For	State of M	aryland / De	epartment of Certificate of	Health and N	Mental Hyg	giene 2	004	0000
				Registrar 1. Decedent's Name (First, Middle, L	a et l		oruncate of	Deam	1	-	004	NARS
4		Physic /Medi		Virginia Belle	Beck				2. Date of Dea Month March	Day	Year	3. Time of Death 2:30 a. M
1		Exami	ner	4a. Facility Name (If not institution, gi			4b. City, Town,	or Location of Death		4c. Count	y of Death	
				Stella Maris Ho			Towso		-		imore	
		Funeral			1 M 2 D F	ge (In yrs. last birtho Yr:	Months Days		8. Date of Birth (Month, Day)	Year)	9. Birthpla Counti	ace (State or Foreign ry)
	×	Director		217-16-4806 Usual Residence of Decedent	X 8:	3	3.		Dec. 10	, 1920	Mary.	Land
		yland		10a. State 10b. County		10c. City, Town o	r Location				10	d. Inside City Limits
		Mar Ind	ţō	Maryland Baltin	more	Parkvil	le					1 ☐ Yes 2 💆 No
		death with the Maryland ms 23a or 28a-f ehow	Funeral Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of	What Countr	ry?
		th wit	a D	2726 Waldor Driv	⁄e		21234	ı	т.	nited	S+ 3+05	•
ė		dea	ner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	13. Was Decedent of If Yes, specify Cub		ecify Yes or No-	14. Rad	e - America	n Indian,
a.m	9	or It		1 Never Married 2 Married	1 ☐ Yes 2 🔯	No	1 ☐ Yes 2X No		Hican, etc.)		ck, White, et	
	8	ural',	db	3 € Widowed 4 Divorced	Year or Dates:		10163 220160	Specify.		Specif	w Whit	e
:30	215-0036	nati	Completed by	15. Decedent's E (Specify only highest gi	ducation a <i>de completed)</i>	(6	ecedent's Usual Occu live kind of work done	during most of work	ing	16b. Kind of B	usiness/Indu	ıstry
2	12	withir noe.	E G	Elementary/Secondary (0-12)	Cotlege (1-4or 5	5+)	e. DO NOT use retire	ed)		Oran II.	- m	
.+	121	iled Hygie ther nt, II		11 years 17. Father's Name (First, Middle, Las	(1	Ho	memaker	10 Mathada Nama	- (Circh Middle)	Own Ho		
2004	an	d be	Be C	James L. Stone	.,			18. Mother's Name		walden Suman	ne)	
2	$\overline{\succeq}$	hould d Me mark matic	2	19a. Informant's Name/Relationship	(Type Print)	105.14	alle Adders (Otto	Anna Mai				
16,	Maryland	d2s than 171e trau			(Type, Filit)		ailing Address (Street					
	a)	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Madical Examiner must be notified at ance.		Joye B. Carneal 20a. Method of Disposition		2726 20b. Place of Di	5 Waldor D.	rive Ba	ltimore,	Maryla 20c. Location -		
MARCH	Baltimore,	ages int of t: If it		1 Burial 2 Cremation 3	Removal from State		sposition (Name of crematory or other pla				·	
¥.	₽	artme ortan ortan injury		* 4 □ Donation 5 □ Other (Special Signature of unitral Service Lice		HITTEOP	Service C		/2004	Towson	, Mary	land
	Ba	Departiment of the second of t		24024	51		Duda-Ruc	k Funeral	Home of	Dundal	lk, In	c.
		19.		23a, Part1. Enter the disease, or con	folications that caused	the death. Do not	$_{-7922}$ Wis	e Avenue	Dundalk	. Mary	and 2	1222
	1	\$. ¥		23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final	one cause on each lin	ne.	emer me mode or dyn	ng, such as cardiac (or respiratory arre	ist,	l l	Approximate nterval Between Onset and Death
		Physician /Medical		disease or condition resulting in death)			T FAILURE					
		Examiner			Due to (or as	a consequence of):						
			e.	Sequentially list conditions,	b. Due to for as	a consequence off;						
		uted	Examiner	flany, leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events								
	Ć.	eath certificate be executed attending physician and for use as the burial-transit	Еха	resulting in death) Last	c. Due to (or as	a consequence of):					_	
	760,	e be rsicia e bur	call		d						ļ	
	.89	ificat g phy as th	edi									
	ŏ	The law requires that the death certificat te has been signed by the attending phy age 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		_			23d Dat	e of delivery	
	Ď	death s atte d for	icia	in the past 12 months? 1 □ Yes 2 🕱 No	1∐Live birth 4∏Pregnant at		3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	/		Moi		ay Year
K	0	that the do	hys	9 Unknown	9□ Unknown							
BECK	σ.	s thai ned t	by P	Part II. Other significant conditions	contributing to death bu	ut not resulting in the	underlying cause giv	en in Part I.	23e. Did toba	acco use conti	ribute to the	cause of death?
	rds	w requires that been signed should be det	b D						1 🗀 Yes	s 2 No	3 Probab	ly 4 Unknown
VIRGINIA	Record	s bee	Completed						24a. Was an			
5	Re	he lav e has age 2 :	Ĕ						autopsy	ed?	rior to comp leath?	y findings available letion of cause of
Ī			ပိ	25. Was case referred to medical					1 Yes 2	X No 1	Yes 2	□ No
	>	Phyaician: this certific ral director.	To B	examiner?	Hospital:	nt 2□ER/Outpat	ont all post Oth	er:				Hogpron
				27. Manner of Death	28a. Date of Injur	y 28b. Time	IBITE 3 DOA	4 Nursing Hon	ne 5 🗌 Resider 28d. Describe hov			HOSPICE
	Division	Attending I r death. actor: After by the funer	Certification:	1 Anatural 5 Pending 2 Accident investigation	(Month, Day	Year) Injur	y Wor	k? Yes 2 ⊟No		· myery cocarr	-	
	/IS	tal or Attendii s after death. al Director; Al ed in by the fu	floa	3 ☐ Suicide 6 ☐ Could not b	286. Place of Inju	ıry - At home, farm,	street, factory, office	2	28f. Location (Stre	et and Numbe	er or Rumi R	oute Number
V	É	Direction of	erti	4 Homicide	building, etc	(Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Town,	State)		02.0 / 1220.;
A		le le le le le le le le le le le le le l		29a. Certifier 1 Certifying Ph	ysician: To the best o	of my knowledge, de	ath occurred at the tin	ne, date and place, a	and due to the cau	use(s) and mar	nner as state	ad .
,		e Ho e Fu letely	edicai	(Check only 2 Medical Exar	niner: On the basis of and manner state	examination and/or	investigation, in my o	pinion, death occurre	ed at the time, dat	e and place, a	nd due to th	e cause(s)
		To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier)		29c. Licens	e number	296	d. Date signed	(Month, Day	y, Year)
4					10		DI	13721		2/	11. 161	1
-		h		30. Name and address of person who	completed cause of de	eath (Item 23a) (Tvn				-//	4/09	/
				DR. TARIO MAHMOO		JLANEY VAI		TIMONIUM,	MD 2100	3		
		Sta	te	31. Date filed (Month, Day, Year)	Registra	r's Signature		TITOM TOLL	TID 2109.	J		
		D 1 - 4		MAK I 4 71UI	n and	AF						

DHMH 17 Rev 1/2001

VIRGINIA BECK

			For State Registrer	State of Ma		artment of F rtificate of			ene∠UU↓ g. No.	08829
			Decedent's Name (First, Middle, La	st)				2. Date of Death Month	1	3. Time of Death
H	Physicia /Medic		Raymond	L.	Butler			March	17, 2004	5:10 A M
	Examin	er	4a. Facility Name (If not institution, given Arden Courts	e street and number)		Towson	r Location of Death		4c. County of Deat Baltimore	
	Funeral			Ag MHM 2□F	e (In yrs. last birthday)		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Jan. 10,		hplace (State or Foreign untry)
	Director			PESTM 2∐F	79 Yrs.	Months Days	Tiours Willis	Jan. 10,	1925 Vi	rginia
	/land		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	e Mar	ctor	Maryland Prince	Georges	Bowie					1 ŽYes 2 □ No
	with th	Director	10e. Street and Number 12705 Haske11 La	n o		10f. Zip Code	0716		g. Citizen of What Co J.S.A.	untry?
	ns 23	erai	12/05 Haskell La	12 Was Decedent	Ever in U.S. 13.		lispanic Origin? (Sp an, Mexican, Puerto		14. Race - Ame	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or Hems 23a or 28a-f show any injury or other traumatic event, I'm Medical Evarities must be routlifted at once.	by Funeral	1 ☐ Never Married 2 🗷 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1	No	If Yes, specify Cuba 1 ☐ Yes 2 ☐XNo	an, Mexican, Puerto Specify:	Rican, etc.)	Specify: White	
9	2 hour	ted b	15. Decedent's E	ducation	16a, Dece	dent's Usual Occup	ation	1	6b. Kind of Business/	Industry
215	ithin 7:	Completed	(Specify only highest gr Elementary/Secondary (0-12)	College (1-4or 5	o+)		during most of work	ing	Veterans	
121	Hygier Hygier ther th		12 17. Father's Name (First, Middle, Last)	Perso	nel Assi	18. Mother's Nam	e (First, Middle, M.		stration
land	ld be fental if	To Be	Orris C. Butl				Ray		urner	
ary	shou and M is mar	-	19a. Informant's Name/Relationship	Type, Print)	19b. Maili	ng Address (Street	and Number or Run	al Route Number,	City or Town, State, 2	lip Code)
S,	l and 2 lealth im 27 I		Margaret M. Butle	r/ Wife	20b. Place of Dispo	5 Haskell	Lane, Bo	Wie, Mar	yland 20	716
Baltimore, Maryland 21215-0036	ages 1 ant of H tt: If ite y or ot		1 ☑ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Speci		cemetery, cre Maryland	Veterans	3/19	100	ownsville	•
altir	mil. P partme portan y injur.		21. Signature of Funeral Service Lice		Cem	etery 2. Name and Addre	1		Evans Fune	
ä	permi Depa Impo any ii		full	8	1	6000 Anna	polis Roa	d, Bowie	, Maryland	20715
ı			23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	plications that caused one cause on each li	the death. Do not en	ter the mode of dyin	ig, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death
ï	Pnysician /Medical		disease or condition resulting in death)	a. Due to (or as	a consequence of):	ONIN				Lary
4	Examiner		Sequentially list conditions	b						V
	ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):					
Ć,	axecut n and al-tran	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consequence of):					
68760,	fficate be executed g physician and as the burial-transit	edical		d						
_	± 00 %	Med	IF FEMALE:	23o If use outcome	of prognancy					
Вох	that the death certi ed by the attending detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deli	very Day Year
P.O.	at the c by the tached	hysi	9 Unknown	9□ Unknown						
	8 E 8	by	Partificent opnditions	contributing to death b	ut not resulting in the u		en in Part I.	23e. Did toba 1 ☐ Yes	acco use contribute to 2 □ No 3 □ Pro	the cause of death?
COL	w requir been si should	letec	00,000		1			24a. Was an	24b. Were au	topsy findings available
Re	The lav	Completed					/	autopsy performe	ed? death?	ompletion of cause of 2 ☐ No
/ital	sicien: Th certificate irector, pag	BeC	25. Was case referred to medical examiner?	l Manaitali		Oth		(Check only one)		Assisted
of	S 50 D	7	1 ☐ Yes 2 ☐ No 27. M → n → of Death	Hospital: 1 Inpatie	ry 28b. Time o	f 28c. Injun	4 ⊟ Nursing Ho	me 5 Residen 28d. Describe how	ce 6 Lener (Spec	(y) Living
ion	nding ath. r: Afte e fune	atlor	1 D atural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Da	y Year) Injury	Worl	k? Yes 2 □ No			
Division of Vital Records,	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	ertification;	3 ☐ Suicide 6 ☐ Could not be determined		ury - At home, farm, sti c. (Specify)	eet, factory, office		28f. Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,
ш	e Hospital or 24 hours afte e Funerel Dir etely filled in	O			of my knowledge, deat					
	To the Ho within 24 I To the Fu completely	ledical	one)	and manner st	f examination and/or in ated.		·			
	To To con	Ž	29b. Signature and title of certifier	Am VI	1 6	29c. Licens		3 m	Date signed (Month	,2004
			30. Name and address of person who	completed cause of d	eath (I em 23a) (Type,	Print)	0 0:	0.4	1 . 1.5	,2004 MD21204
	VK1		M DAY CY	MC 6	70 N	CHARL	(5) ST	1781	IMOGE	1111) 11704
ije.	Sta Registr		31. Date filed (Month, Day, Year) MAR 1 9 2004	See 1	4 April					

			1 - For State Registrar	State of Marylar	nd / Depa <i>Cei</i>	artment rtificate	t of He	ealth ar Death		Ne.	g. No.	004	08830
	Physici /Medio Examir	al	Daniel Clemen Aa. Facility Name (If not institution, give	t Bentrem		4b. City,		Location of	Death	Date of Death Month	Day 4c. Cor	Year)04 unty of Death	3. Time of Death
	Funeral Director		229-19-0111			If Under Months		Itimo: If Under 24 Hours		Date of Birth (Month, Day, PLEMBEY 2	ł.,	9. Birthpl	ace (State or Foreign try) Inja
	death with the Maryland ims 23a or 28a-f ahow f must be notified at	ctor	Usual Residence of Decedent 10a. State 10b. County Virginia Harrisonbu		y, Town or Lo	burg		7					0d. Inside City Limits 1 ☐ Yes ※ ※ No
	ath with the 23 or 21 unit by no	rai Dire	10e. Street and Number 846 Sugar Maple L				801				U	of What Coun	
980	72 hours after des natural, or Items dical Examination	Completed by Funeral Director	11. Marital Status XX Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 Yes XX No If Yes, Give Year or Dates:		Was Deced If Yes, spec 1 Yes 2	ify Cuban	panic Origir , Mexican, I Specify:	n? (Specil Puerto Ric	ly Yes or No- can, etc.)		Race - America Black, White, e ecify: W	
21215-0036	filed within 72 ho Hygiene. other than "natu	ompletec	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)		(Give	dent's Usua kind of wor DO NOT us .udent	rk done du se retired)	tion uring most o	of working	11		of Business/Ind	
Maryland 2	2 should be filed and Mental Hyg I a marked othe raumatic event,	To Be C	17. Father's Name (First, Middle, Last) George Bentrem					Eliza	abeth	First, Middle, Ma 1 Torrij	os		
re, Mar	es 1 and 2 sh of Health and of Item 27 la m r other traum		19a. Informant's Name/Relationship (1) George Bentrem 20a. Method of Disposition	Father 20b. F	1	ugar	Map I	e Lane	e Har	9 20	ırg,		ia 22801
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 Ia marked other than "natural", or Items 23a or 28a-f ahow any injury or other traumatic event, the Mudical Exprinter must be notified at ance.		1 ★ Denation 5 □ Other (Specify 2) Square of Funeral Service Licen	Woo	odbine	Cemet	ery	3, of Facility		04 Ha mell-Wiede Road Balti	efeld	Funeral	
)	Physician /Medical		23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	dications that caused the deal one cause on each line. a	and	1			ardiac or r			rarylar	Approximate Interval Between Onset and Death
8760,	death certificate be executed e attending physician and id for use as the burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infiated events resulting in death) Last	b. Due to (or as a consect Due to (or as a consect d.									
P.O. Box 68		Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregn. 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of c	ıl death 3□	Ectopic pre					23d.	Date of deliver Month	ry Day Year
	sign sign d be	þ	Part II. Other significant conditions of	ontributing to death but not res	ulting in the u	nderlying ca	ause giver	n in Part I.			2 X N		e cause of death?
Vital Records,	The ate h page	Completed								24a. Was an autopsy performe 1 Yes 2		prior to com death?	sy findings available indicate of 2 No
of Vit	Physician: Th r this certificate ral director, pag	To Be	IK Tes 2 No		ER/Outpatien		A Other	. 4 ☐ Nurs	ing Home	5 Residen	ce 6 □)
Division	tending leath. tor: After the fune	Certification:	27. Manner of Death 1 Natural 2 Q Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined	3-0-07	ome, farm, str	РМ	, office	es 2 No	28f	Location (Stre City or Town,	drowing with the state of the s	the Ocid	Route Number,
	To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my kno liner: On the basis of examina and manner states.	owledge, death ation and/or inv	occurred a vestigation.	at the time in my opi	e, date and p nion, death	place, and occurred	d due to the cau at the time, date	se(s) and	manner as sta	ited.
	To the To the Comp	Σ		mid			License O.	number C.M.E.	•	1		gned (Month, E h 15, 2	
	(1		30. Name and address of person who declared to the second	Q		Print)	Penn	Stree	et, E	Baltimor	æ, M	Maryland	1 21201
	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature	Some	1/2/						

			For Stata Registrar	State of Maryland / Del	partment of Health and M e <i>rtificate of Death</i>	Mental Hygier Rag.		08832
			1. Decedent's Name (First, Middle, Last,)		2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medio		SEUNG	CHA		MARCH I	7 2004	807 AMM.
Н	Examin		4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location of Death		4c. County of Death	•
			Good Samarit	an Hospital	BALTIMORE			
	Funeral		5. Social Security Number 6. Sec	du alla	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	9. Birthpl Gount	lace (State or Foreign try)
	Director		210-31-3000	Yrs.		5-24-1	920 KOR	ELA .
	and *		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or	Location		10	Od. Inside City Limits
	sho	ŏ	m	DA	- 0.7			1 No 2 No
	286-1	Director	10e, Street and Number	DHU	10f. Zip Code	100	Citizen of What Coun	try?
	with	ᅙ		1).4	21201		115A	,
	eath	Funeral	5 22 YORK	12. Was Decedent Ever in U.S. 13	3. Was Decedent of Hispanic Origin? (Sp	pecify Yes or No-	14. Race - America	an Indian.
	ter d	Fun	1 Never Married 2 Married	Armed Forces?	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, e	etc.
98	urs a	þ	3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ♠ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify:	PPAN
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Itams 23a or 28e-f show ha Mudical Exaita ar must be indiffed at	Completed by	15. Decedent's Edu		cedent's Usual Occupation	16b	. Kind of Business/Ind	lustry
21	hin 7	ple	(Specify only highest grad	College (1-4or 5+)	ve kind of work done during most of work . DO NOT use retired)	ang	Λ	
7	giene giene	5	12	KOR	ZEAN Militar	4	HRMY	
힏	al Hy othy vent	Be (17. Father's Name (First, Middle, Last)	<i>(</i>).	18. Mother's Nam	(First, Middle, Maid	len Sumame)	
<u>a</u>	Menta Menta Prked	10 E	UN Tae	Cha.	Wha	JA	Lee.	
Maryland	2 sho and I is ma	1 3	19a. Informant's Name/Relationship (Ty	rpe, Print) 19b. Ma	iling Address (Street and Number or Rui	ral Route Number, Cit	y or Town, State, Zip	Code) 21093
≥ `	and and in 27		Jung Won	Cha 213	29 Fountain Hil	1. DRIVE,	Lutterovil	le ms
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural; or Itams 23a or 28e-f show any injury or other treumatic event, the Mudical Experiment must be usuallised at Once.		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ F	comoton, o	position (Name of rematory or other place)	Date 20c.	Location - City or To	wn, State
Ĕ	Pag nent ent: I		`4 □Donation 5 □Other (Specify)	DukaneuVa	NeuMen Gardens 3-1	9-04 IT	monium	mD
ä	poartr poort y inj		21. Signature of Funeral Service Licens	88	1 New Complete 3-1, 22. Jame and Address of Facility 237	SYORKRD	Timeniur	m, mozice
m	82589		Kimberler W.	MUNORY H	EREFUL ALTERNATIVE	SFUNERAL	CREMATIO	NCENTER
			23a. Part1. Enter the disease, or compleshock, or heart failure. List only of	idations that caus of the death. Do not e	enter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	ASCUD			U	Onset and Death
	/Medical		resulting in death)	Due to (or as a consequence of):				/ (0 0 /
	Examiner		Sequentially list conditions,	D				
	D #	ner	if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):				
	ecute ind trans	Examlne	that initiated events resulting in death) Last	c				
Ö,	e exe ian a urial-		resulting in death) cast	Due to (or as a consequence of):				
8760,	cate be executed physician and the burial-transit	dlcal		d				
9		Me	IF FEMALE:	220. If you guiteeme of programmy	-			
Box	death certifii e attending p od for use as	ian/	23b. Was decedent pregnant in the past 12 months?		B Ectopic pregnancy		23d. Date of deliver Month	ry Day Year
o. —	0 0 0	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of death : 9□Unknown	Other (specify)			
<u>α</u>	requires that the de seen signed by the hould be detached		Part II. Other significant conditions con	ntributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobaco	co use contribute to the	e cause of death?
ds,	Se Log	þ		,	3	1 ☐ Yes		
Record	w requir been si should	Completed						
ec €	S 53 CA	Ig I				24a. Was an autopsy performed	prior to con	psy findings available appletion of cause of
ᆵ	: The licate ha					1 ☐ Yes 2 ☐		2 2 N o
of Vital	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	fospital:	Other	th (Check only one)		
o	S ∞ =	2	1 Yes 2 No	1 ☐ Inpatient 2 ☐ ER/Outpat 28a. Date of Injury 28b. Time	ient 3 DOA 4 Nursing Ho	ome 5 Residence 28d. Describe how in	6 ☐Other (Specify,)
	After	lon	1∠Natural 5 ☐ Pending	(Month, Day Year) Injury		Ecc. Doscribe now ii	in the second se	
<u>S</u>	ten leat lor: the	lca	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At home, farm,		28f. Location (Street	and Number or Rural	Route Number.
Division	를 를 들는 드	Certification;	4 Homicide determined	building, etc. (Specify)	ottoot, taolory, ontoo	City or Town, St.		
_	Hospitel 14 hours a Funerel I	C	29a. Certifier 1 Certifying Phy	sician: To the best of my knowledge, de	ath occurred at the time, date and place.	and due to the cause	e(s) and manner as sto	ated.
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	edica		ner: On the basis of examination and/or and manner stated.				
	To the within 2 To the comple	Me	29b. Signature and title of certifier		29c. License number	29d. l	Date signed (Month, E	Day, Year)
	> - 0		> traa	J. 52.50.	1 18230		3/17/	104
	^		30. Name and address of person who co	ompleted cause of death (Item 23a) (Typ	e, Print)		(
	7			>	OD SAMARITA	7 1910H N	AL, M	0 21239
	Sta	ate	31. Date filed (Month: Day, Year) • MAR 1 9 2004	32. Registrar's Signature	Ma			
	Registi	rar	· MAK I 3 ZUU4	Flow St Figure				

			1 - For State Registrar	State of Man	yland /		rtment of H		-	~ ^ *	06	0883
	Physici /Medi		Decedent's Name (First, Middle, Last)	Dianne	М.	Cold	lwell		2. Date of De. Month () 3 -		Year	3. Time of Death 5/4/0 9M
	Examir Funeral		4a. Fecility Name (If not institution, give str Franklin Bauare Hosp. 5. Social Security Number 6. Sex	tal Center	n yrs. last l		4b. City, Town, or ROSE dale If Under 1 Year Months Days	Location of Deat If Under 24 Hrs Hours Min.		4c. County	MUTE 9. Birtho	lace (State or Foreign
	Director		217-60-2563 Usual Residence of Decedent 10a. State 10b. County		51 Dc. City, To	Yrs.	ation		Jan.1	3,1953		viand Od. Inside City Limits
	death with the Maryland ms 23s or 28s-f ehow must be notified at	ector	MD Baltimo	re		Es	sex			10-02		1 ☐ Yes 2 ☐ No
	th with	a Dir	315 Sassafras R	oad			10f. Zip Code 212:	21		10g. Citizen of V USA	vnat Coun	try?
Marie	9 4 8	d by Funeral Director	11. Marital Status 12 1 Never Married 2 Married 3 Widowed 4 Divorced	. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	r in U.S.		as Decedent of Hi Yes, specify Cuba	spanic Origin? (S n, Mexican, Puerl Specify:	pecify Yes or No- o Rican, etc.)		e-Americ k, White, hite	etc.
	within 72 hours after ene. then "natural", or Ite in Medical Expirit	Completed	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12) 12th	completed) College (1-4or 5+)		(Give k	nt's Usual Occupa ind of work done of DNOT use retired laker	ation furing most of wor)	rking	own ho		lustry
ianne	al Hygir I other	Be C	17. Father's Name (First, Middle, Last)					18. Mother's Nan	ne (First, Middle,			
	2 should be filed within and Mental Hygiene. Is marked other then aumatic event, the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Mental control of the Men	2	John J. Aul		10	Ph Mailing	Address (Street a		A. Kett		State Tie	Cadal
	and 2 seath ar		Kenneth Coldwel	l/husban	d	315	Sassai					
Coldwell]	permit. Peges 1 and 2 should Department of Health and Men Important: If item 27 is marke eny injury or other traumatic.		20a. Method of Disposition ↑▼ Burial 2 □ Cremation 3 □ Ren • 4 □ Donation 5 □ Other (Specify)	sound from State	cemel	tery, crema	tion (Name of atory or other place Memori		Date 22/04	20c. Location - Baltim		
Balt	permit. Departimporti		21. Signature of Funeral Service Licensee	Ohne	lle	22.	Name and Addres	_	Connell ve. Ba	yFunera ltimoe	alHo MD	meofEsse: 21221
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infitted events	Due to (or as a co	<u>Cane</u>	e of):	the mode of dying	g, such as cardiac	or respiratory an	rest,		Approximate Interval Between Onset and Death O MON HAS
68760.	cate be chysicial the buri	dical	resulting in death) Last	Due to (or as a co	onsequence	e of):						
Вох	eath cert attendin for use	by Physician/Me	IF FEMALE: 23b Was decedent pregnant in the past 12 months? 1 □ Yes 2 MNo 9 □ Unknown	If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal deal		ctopic pregnancy Other <i>(specify)</i>			23d. Date Mor	of deliver	ry Day Year
rds, P	v requires that been signed b should be det	ed by P	Part II. Other significent conditions contri	buting to death but no	ot resulting	in the und	erlying cause give	n in Part I.				e cause of death?
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of V	Physicia this cert at direct	To Be	examiner? 1 Yes 2 No Hos		2 🗆 ER/C	Outpatient	3 DOA Othe	~	th Check only or ome 5 Resid		r (Specify))
Division o	or Attending Ph ifter death. Director: After th in by the funeral	Certification:	2 Accident investigation	28a. Date of Injury (Month, Day Ye	28b.	. Time of Injury	28c. Injury Work M 1 🗆 Y	at ? 'es 2 □ No	28d. Describe h	ow injury occurre	ed .	
Divi	i Si te	Certifi	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (S	At home, to pecify)	farm, stree	t, factory, office		28f. Location (S. City or Town	treet and Numbe n, State)	r or Rural	Route Number,
	To the Hospitel within 24 hours a To the Funeral Completely filled	Medical	29a. Certifier 1 Certifying Physici (Check only one) 2 Medical Examiner	an: To the best of m : On the basis of exa and manner stated.	imination a	ge, death o and/or inve	ccurred at the time stigation, in my op	e, date and place, inion, death occur	and due to the c rred at the time, d	ause(s) and mar late and place, a	ner as stand due to	ted. the cause(s)
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	y		Dr. 2aud Eldadah	1000 From	Klin C	Type, Pr	7	Baltin	03 /1 nore Mo	1212:	37	
	Sta Registr		31. Date filed (Month, Day, Year) MAR 1 9 20	32. Registrar's S	Signature	6	Low	that	· · · · · · · ·	-, , 64		

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t. Pages 1 tment of H rtant: If Ital	1 Burial 2 Cremation 3 C	fy)	20b. Place of Disp cometery, cr Winters	Cemete	ry	3-19-	4	New W	tion - City or To Vindsor,	Md
	21. Signature of Funeral Service Lice	W	P	.0. Box	x 195	Sykesv	ille, M	ld 217	Home &	Chape1 Approximate
/Medical Examiner	23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequence of):	(· C	0101	y U	hoch-	Dise	~/~	Interval Between Onset and Death
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	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death 3	□Ectopic preg □ Other (spec				23	d. Date of delive Month	ry Day Year
w requires that been signed by should be deta	Part II. Other significant conditions Dement.	contributing to death be	ut not resulting in the	underlying cau	ise given in F	Part I.				e cause of death
							24a. Was auto perfo 1 \(\text{Yes} \)	psy ormed?	24b. Were autop prior to con death? 1 Yes	osy findings availanteletion of cause
Physician: this certific ral director, TO Be C	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	nt 2 ☐ ER/Outpati	2 004	0.1	-	h (Check only o		□Other (Specify	-1
\$ 2 E	27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injur (Month, Day	v 28b. Time		injury at Work? 1 ☐ Yes		28d. Describe)
o the Hospital or Attending P Thin 24 hours after death. The Funeral Director: After the Implately filled in by the funeral Medical Certification;	3 Suicide 6 Could not to determined	building, etc					City or To	wn, State)		l Route Number,
To the Hospital or within 24 hours after To the Funeral Dir completely filled in Medical Cert	(Check only 2 Medical Exa	hysician: To the best of miner: On the basis of and manner sta	examination and/or	nvestigation, in	n my opinion	, death occurr	and due to the red at the time,	date and p	lace, and due to	the cause(s)
_	29b. Signature and title of certifier		0	0	License num アファ	8 ?		3/18	signed (Month, L	
	30. Name and address of person who are the second of the s	054 1/7	eath (Item 23a) (Type ar's Signature	Print)	ent-	Di	ve 1	Ceir,	fantor	un Mil zi

d.

			State of Maryland / De	partment of Health and Ment ertificate of Death	
	Physici /Medio Examir	al	Decedent's Name (First, Middle, Last) Yinshia Wei Chen 4a. Facility Name (If not institution, give street and number)	N	Date of Death Month Day Year rch 15, 2004 8:55A
	Funeral Director		8907 Burdette Road 5. Social Security Number 6. Sex 1	Bethesda y) If Under 1 Year If Under 24 Hrs. a. D. (A. Months Days Hours Min. Se	Montgomery late of Birth Month, Day, Year) pt. 10,1908 Taiwan
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or Items 23a or 28a-f show any injury or other traumatic event, the Marical Examiner mat be multiked at once.	To Be Completed by Funeral Director	10e. Street and Number 8907 Burdette Road 11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) Teh Wei 19a. Informant's Name/Relationship (Type, Print) Sue Liu/Daughter 20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Removal from State 11. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates: 16a. Dec. (Gi Ilife 17. Father's Name (First, Middle, Last) Teh Wei 19a. Informant's Name/Relationship (Type, Print) 20b. Place of Disposition 1 □ Burial 2 ☑ Cremation 3 □ Removal from State 1. Signature of Europal Service Lineages	10f. Zip Code 20817 B. Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Rican 1 Yes 2 No Specify: Dedent's Usual Occupation re kind of work done during most of working DO NOT use retired) 18. Mother's Name (First illing Address (Street and Number or Rural Rought 7 Burdette Road: Bether promotion (Name of templace) Park Crematory 03/17/2	Specify: Asian 16b. Kind of Business/Industry Public Schools st. Middle, Maiden Sumame) (unk) ute Number, City or Town, State, Zip Code) esda MD 20817 20c. Location - City or Town, State
68760,	physician and water the burial-transit stife burial-transit	edicai Examiner	23a. Part. Enter the disease, or complications that caused the death. Do not eshock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Congestive Heart Due to (or as a consequence of): Due to (or as a consequence of): Diabetes Mellitu	: Failure	Approximate Interval Between Onset and Death
O. Box	that the death certifica ed by the attending ph detached for use as th	Physician/Med		B⊟Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year
Records, P	e law requires has been sign je 2 should be	Completed by Ph	Part II, Dther significant conditions contributing to death but not resulting in the Renal Failure		23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy findings available prior to completion of cause of death? Yes 2 No
Division of Vital	ng Physician: ifter this certifica ineral director,	Certification: To Be C	25. Was case referred to medical examiner? 1	26. Place of Death (Che ent 3 DOA Other: 4 Nursing Home of 28c. Injury at Work? M 1 Yes 2 No street, factory, office 28f. Le	Z 100 - X 110
Ö	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical Cer	29a. Certifier 1X Certifying Physicien: To the best of my knowledge, de (Check only 2 ☐ Medicel Exeminer: On the basis of examination and/or	ath occurred at the time, date and place, and di	ue to the cause(s) and manner as stated.
•	To the Yeithin 2 To the complet	Med	29b. Signature and title of certifier 29b. Name and address of person who completed cause of death (Item 23a) (Type)	29c. License number D13339	29d. Date signed (Month, Day, Year) March 16, 2004
	5 Sta Registi			Drive; Berwyn Height	s, MD 20740

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2001 08836 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month **Physician** MYCHAJLO 18. 12:30 a[™] March 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner N/A 1420 Elmtree Street Baltimore If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 □ F Director 218-30-6361 90 23, 1913 Ukraine Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow 27 is marked other than "natural", or itams 23a or 28a-f abovermetic event, the Madical Example required by Baltimore Maryland N/A 1 X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1420 Elmtree Street 21226 Ukraine Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: ð Specify: White 3 Widowed 4 ☐ Divorced ear or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use relired) Elementary/Secondary (0-12) College (1-4or 5+) f Health and Mental Hygiene. Item 27 is marked other than othar traumatic event. Ins M Teaching Ukrainian History Professor 12 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Unknown Gregorij Choma ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (SON) Mr. Roman I. Choma 106 Fifteenth Ave., Baltimore, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State St. Michael's Cem. 3/20/04 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fuperal Service Licensee Kevin E Ecker 22. Name and Address of Facility Funeral Home, P.A. 237 E. Patapsco Ave., Balto., Md. 21225-1856 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** ORONAR disease or condition resulting in death) SV3 MMEDIATE /Medical Due to (or as a consequence of): Examiner EARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): attending physician for use as the buria Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has burector, page 2 s autopsy performed BENIGN 1 Tes Hospitel or Attending Physician: 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) Hospital: Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1. Natural 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 5 Pending 1 ☐ Yes 2 ☐ No death. 2 Accident investigation within 24 hours after death

To the Funeral Diractor:
completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide tacertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

Registrar
DHMH 17 Rev 1/2001

State

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

SHER

32. Registrar's Signature

4710 PENNINGTO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A

31. Date filed (Month

		State of Maryland / Department of State Unpend Item #23a,pt.II,27,28a-f per me C830,4144 Registrar 1. Decedent's Name (First, Middle, Last)	Or Death	2. Date of De		3. Time of Death
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/Medic Examin			wn, or Location of Do		4c. County of De	eath
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Months 1 Months 1 Months 1		8. Date of Bin (Month, Da 6-29-8		Birthplace (State or Foreign Country) [d.
and *		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
Maryl	tor	Md. Wicomico Salisbury				1 ☐ Yes 2 💆 No
vith the Marylar t or 28a-f ehow	Director	10e. Street and Number 10f. Zip Co	ode		10g. Citizen of What	Country?
ath w	ral	1000 1111-1	1801		USA	1
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		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		<u>`</u>		
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Maryland 21215-0036	2 sho and h la ma	١.	19a. Informant's Name/Relationship (Type, Prin	t)	19b. Mailir	ng Address (Street a	and Number	or Rural Route Numb	er, City o	or Town, State, Zi	ip Code)
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			For State Registrar	State of	Marylar		artment of tificate o			lental Hyg	iene eg. No. 2	004	08839
	Physici /Medic		1. Decedent's Name (First, Midd Evelyn		ckers			-		2. Date of Dea Month	th Day	Year	3. Time of Death 10:30a ^M
	Examir		4a. Facility Name (If not institution Wesley Home	-	ber)		46. City, Town	nore				ty of Death	13.034
	Funeral Director		5. Social Security Number 219-30-4016 Usual Residence of Decedent	6. Sex 1 □ M 2 💢 F	7. Age (In yrs. 95	last birthday) Yrs.	If Under 1 Year Months Day		24 Hrs. Min.	8. Date of Birth (Month, Day, Sept 08	, 1908	Cou	place (State or Foreign htry) yland
	be filed within 72 hours after death with the Maryland tal Hygiene. dother then "natural", or Itams 23e or 28e-1 show avent, the Medical Exarther coust be confilled at	Funeral Director	10a. State 10b. Count Md. Balti 10e. Street and Number 7929 Rold1 11. Marital Status 1 Never Married 2 Ma	LMOTE 12. Was Decerated Armed Formed Interest 1. Types	Ball	ŀ	10f. Zip Code 21 2[Nas Decedent of Yes, specify Co]4 of Hispanic Ori uban, Mexicar		ocity Yes or No- Rican, etc.)		f What Cou	SA can Indian,
Maryland 21215-0036	filed within 72 hours a Hygiene. other then "neturel", o ent, the Medical Exam	Completed by	3X Widowed 4 □ Divorce 15. Decede (Specify only high) Elementary/Secondary (0-12) 12	d If Yes, Giv. Year or Da nt's Education est grade completed) College (1-	tes:	16a. Deced (Give life. L	lent's Usual Occident of work dor NOT use return 1 Teach	cupation ne during mos ired)	t of workii	ng		Business/In	White
ryland	S should be filed and Menta! Hygi Is marked othar aumatic avent,	To Be	17. Father's Name (First, Middle Harry Banka 19a. Informant's Name/Relation	ırd		19b Mailin	a Address (Stre	S	tell	(First, Middle, I a Staine I Route Number	es		Code
altimore, Ma	Pages 1 and 2 nent of Health ant: If item 27 I ury or other tre		Shirley A. Nei 20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (lson/ Daug	20b. F	7925 Place of Dispos		ew Ave.	Bal	timore,		1 204 - City or To	own, State
Ball	permit. Pag Department Important: any injury once.		21. Signature of Funeral Service	15		_	1050	: Towso York	n Fui Rd	neral Ho Towson,	Md. 2	nc. 1204	
	Pnysician /Medical		shock, or heart failure. Life Immediate Cause (Final disease or condition resulting in death)	a. END	or as a conseq	1GE	DiMU			r respiratory arre	951,		Approximate Interval Between Onset and Death
8/60,	death certificate be executed a ettending physician and d for use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	1. CER	T/ -1 or as a conseq 273 Ro or as a conseq	VASC			SEA.	ALOPI SE	7771		YUAR YUARS
O. Box 6	that the death certific ed by the attending p detached for use as a	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown		th 2 ☐ Feta .nt at time of d	al death 3 🗍	Ectopic pregnar Other (specify)					ate of delive	ory Day Year
cords, P.	sign d be	by	Part II. Other significant condit	ions contributing to dea	ath but not res	sulting in the un	derlying cause o	given in Part I.			acco use con	ntribute to th	ably 4 Unknown
ğ	The law ate has b page 2 sl	Completed								24a. Was ar autops perform 1 Yes 2	24b.	Were autoprior to cordeath?	psy findings available inpletion of cause of
ion or vital	ng Phys fter this ineral dii	ation: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death Adatural 5 Pendi invest	Hospital: 1 ☐ In 28a. Date of		ER/Outpatient 28b. Time of Injury	28c. Inj	other: 4 Nu	rsing Hom 2	(Check only one ne 5 ☐ Reside 8d. Describe ho	nce 6 □Ot)
Division	To tha Hospital or Attandi within 24 hours after death. To tha Funaral Director: A completely filled in by the fu	Certification:	4 Homicide	mined 286. Place of buildin	g, etc. (Specif	y)	et, factory, offic		(8)	8f. Location (Str City or Town	, State)		
	To tha Hospital or At within 24 hours after d To tha Funaral Direct completely filled in by	Medical	29a. Certifier (Check only one) 2 Medical 29b. Signature and title of certifier	ng Physician: To the base and manners	sis of examina	owledge, death ation and/or inv	estigation, in my	time, date and opinion, deat	d place, a th occurre	d at the time, da	ite and place	and due to	the cause(s)
	T will		30. Name and address of person	2. Vely	mD.	n 22a) /Ti 1	1		5		3 - 17		
	5 Sta	te	ROBERT E. R. 31. Date filed (Month, Day, Year	0 BY M.D	ZZ/I gistrar's Signa	W - RO	GERS	AVE-	BAL	-AMOR	MI	21	209
	Registr		MAR 1 9	2004	un l	1	the same						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2004 **Physician** March 7, 01:36 PM ALBERTA KATHERINE ESTEP /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Good Samitan Hospital Baltimore If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs, last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 ☐ F Director 82 8/11/1921 MARYLAND 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner intest be nutified at 1 ☐ Yes 2 ☐ No Director BALTIMORE NOTTINGHAM 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Itema 23a or 22 REDDUBG COURT 21236 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. ont: If item 27 is marked other than "natural", or Itei 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: 3√ Widowed 4 Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PAYROLL CLERK NATL. SEC. ADMIN. 12TH GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ALBERT ERNEST LUDWIG ျှ ELSIE MARIE KRAUSS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DALE HURD SON-IN-LAW 2807 REST HAVEN ROAD YAKIMA, WASHINGTON 98901 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot 1 ⊋Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐Donation 5 ☐ Other (Specify) MEADOWRIDGE MEM. 3/12/2004 ELKRIDGE, MD PK. 21. Signature of Funerat/Service Licensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Atteroscionom CARDIDYASCULLA **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed physician and Due to (or as a consequence of) Completed by Physiclan/Medical attending f IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown ģ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? DIANGLES HELLIUS 3 Probably 4 Nhknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has autopsy certificate 1 Tyes 2 No 1 Yes 2 No Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient

②CER/Outpatient 2 1 X Yes 2 □ No 3□ DOA 27. Manper of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 Pending investigation I Director: And in by the fi 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours are.
To the Funeral Dir To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner. On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. March 8, 2004 MM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201 MARGARITA

State Registrar

MAR 1 9 2004

31. Date filed (Month, Day, Year)

RELL 32. Registrar's Signature

P.O. Box 68760.

of Vital Records,

Division

		1 - For State Registrar	State of Mar	yland / Depa	artment o	of Health and of Death	Mental Hyg	giene 200	
Physic /Medi Exami	cal	Decedent's Name (First, Middle, Last Edith 4a. Facility Name (If not institution, give)	E.	Fu	1SS 4b. City. Tow	m, or Location of Dea	2. Date of Dea Month March	Day Yea 15 2004 4c. County of De	0902 ^M
Funeral Director	ner	Anne Arundel Medi 5. Social Security Number 6. Sec 577–42–5419	cal Center	In yrs. last birthday) 90 Yrs.	Annapo	olis	8. Date of Birth	Anne Ar	
the Maryland 28e-f show	ector	Usual Residence of Decedent 10a. State 10b. County MD Queen Ann 10e. Street and Number		Oc. City, Town or Lo		40		Og. Citizen of What	10d. Inside City Limits 1 ☐ Yes 2 ☒ No
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural", or Items 23a or 28e-f show any injury or other treumatic event, the Medical Examinar must be notified at once.	y Funeral Director	105 Worchester Ro	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates:	1	21	L666 of Hispanic Origin? (S Cuban, Mexican, Puer		USA	nerican Indian,
21215-0036 sd within 72 hours att gjene. er than *natural; or the Maxical Exami	Completed by	15. Decedent's Edu (Specify only highest grad	cation	(Give	dent's Usual Ockind of work do NOT use re tant Ma	one during most of wo tired)	rking	16b. Kind of Busines Publishi	ss/Industry
Maryland 2 Id 2 should be filled it is marked other. Treumatic event, it	To Be C	17. Father's Name (First, Middle, Last) Edward Dove 19a. Informant's Name/Relationship (Ty	pe, Print)			18. Mother's Na		a Anderso	
Baltimore, Misomit. Pages 1 and 2 Department of Health a mportent: If item 27 is any injury or other tree		Robert Fuss (Husb 20a. Method of Disposition 1 \(\overline{\mathbb{X}}\) Burial 2 \(\overline{\mathbb{C}\) Cremation 3 \(\overline{\mathbb{P}}\) 4 \(\overline{\mathbb{D}\) Onther (Specify)	lemoval from State	105 20b. Place of Dispo cemetery, crem	Worches sition (Name of natory or other	ter Road,	Stevensv	ille, MD 20c. Location - City (21666 or Town, State
Balti permit. I Departm Importer any inju		21. Signature of Funeral Pervio	cations that caused the	22	Name and Ad Hardest 12 Ridg	dress of Facility y Funeral ely Avenue	Home, P.	lis. MD 2	
Physician /Medical Examiner	_	snock, or near tailure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions.	Due to (or as a co	onsequence of):	t ao	to Card		pathy	Interval Between Onset and Death
oa root of care be executed physician and sthe burial-transit	licai Examiner	il eiy, leadi gi chimnediale cause. Enter Underyling Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co						
the death certif	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetal death 3	Ectopic pregna			23d. Date of d Month	elivery Day Year
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ORIGINAL

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MARCH 18, 2004

LOLA GRAHAM

ORIGINAL

		1 - State AMEND ITEM #7 PE						Reg. No.	2004	0884
Physici /Medio	al	Decedent's Name (First, Middle, Last Eleanor 4a. Facility Name (If not institution, give)	Anne	Caray	City, Town, or	Location of De	2. Date of De. Month	Day 14/2	Year	3. Time of Death /0 : 20 @ M
Examir Funeral Director	ier	University of Mary 5. Social Security Number 6. Se 015-28-2367	land Medical 3	ystems	Balti nder 1 Year		rs. 8. Date of Bin	th y, Year)	9. Birthe	olace (State or Foreign ntry) sachusetts
Maryland a-f ehow	tor	Usual Residence of Decedent 10a. State 10b. County MD Queen		Town or Location	11e				1	1 ☐ Yes 🏖 📉 No
be filed within 72 hours after death with the Maryland lial Hygiene. d other than "natural", or Itama 23a or 28a-f show event, it a Medical Exaction mine it is collised at	by Funeral Director	10e. Street and Number 200 Terrapin Gro 11. Marital Status 1 □ Never Married 2 ☒ Married	Ve, #317 12. Was Decedent Ever in U. Armed Forces? 1 MYes 2 □ No It Yes, Give Year or Dates.	S. 13. Was D			(Specify Yes or No erto Rican, etc.)	- 1	USA 4. Race - Americ Black, White, Specify: WI	can Indian,
na na	Completed b	3 Widowed 4 Divorced 15. Decedent's Edi (Specify only highest grade) Elementary/Secondary (0-12)	ucation		f work done of T use retired	ation during most of v	vorking		d of Business/In	dustry
should be filed within nd Mental Hygiene. marked other than amatic event, it a Mi	To Be Cor	12 17. Father's Name (First, Middle, Last) William Sawyer		Homemal	ker		lame (First, Middle, n Carkin		wn Home Gumame)	
permit. Pages 1 and 2 should by Department of Health and Menta Important: If Item 27 Is marked eny injury or other traumatic engoce.		19a. Informant's Name/Relationship (7) James E. Gray (H	usband)	200 Ter	rapin	Grove,	#317, Ste	vens	ville, N	1D 21666
it. Pages 1 riment of H riant: If Ite njury or oth		20a. Method of Disposition 1 Burial 2 Cremation 3 1 4 Donation 5 Other (Specify 21. Signature of Funeral Service Ligen) Met	lace of Disposition emetery, crematory		3/	Date 17/2004		timore,	
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To the Hospital or Attand within 24 hours after death To the Funeral Director: completely filled in by the	Medical		ysician: To the best of my kno inner: On the basis of examina and manner stated.			pinion, death oc	ccurred at the time,	date and p	place, and due to	Day, Year)
10		30. Name and add ass of person who. SANE LEE, U	completed cause of death (Item	n 23a) (Type, Print)	MD	Me	dical	S	14/04 15tem	ıs
St Regist	ate	31. Date Wady (Month, Day, Year)	32. Registrar's Signa	iture					/	

				For State Registrar	State of Maryland	d / Depa <i>Cer</i>	rtment of Hea	ilth and M eath		giene 2 (004	08846
				1. Decedent's Name (First, Middle, La.					2. Date of De	ath	Van	3. Time of Death
	н	Physici /Medic		ELMIRA G	RIFIN				Marci	1 5 2	Year	12:05 PM
		Examin		4a. Facility Name (If not institution, give	e street and number)	1	4b. City, Town, or Loc		•	4c. County		
7				CENESIS Elderems	CATORSUITE L		CAPONI	Under 24 Hrs.		SATIA		
8		Funeral		5. Social Security Number 6. S	6ex 7. Age (In yrs. Ia ☐ M 2 St 90	ast birthday) Yrs.		ours Min.	8. Date of Bir (Month, Da	th ly, Year)	Coun	lace (State or Foreign try)
3		Director	-	Usual Residence of Decedent	1 70				Apr. J.	2,1913	One	977.0
17		laryland show		10a. State 10b. County		, Town or Lo					1	Od. Inside City Limits
0		a-1st	to	norghin n/a	B	Altip	esk					N⊕Y65 2□NO
72		if the or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of V	-	try?
Mira		death with the Maryland ims 23s or 28s-1 show finust be notified at		0,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	12. Was Decedent Ever in U.S	2 12 1	Ja Decedent of Histor		city Ves or No	US	e - Americ	an Indian
3		Item de	by Funeral	11. Marital Status 1 Never Married Married	Armed Forces?	3. V	las Decedent of Hispa Yes, specify Cuban, M	lexican, Puerto	Rican, etc.)	Blac	k, White,	
-	936	urs af	b	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1	☐ Yes 2, ☐ No S	pecify:		Specify	13/	acle
100	50	within 72 hours after ene. than "natural", or Ite he Medical Exemen	Completed	15. Decedent's E	ducation ade completed)	(Give	ent's Usual Occupation		na	16b. Kind of Bu		
	21	ithin 96.	dr.	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	O NOT use retired)			2:4	/	
	121	filed within Hygiene.		17. Father's Name (First, Middle, Last,]	50	MES HC	Mother's Name	(First, Middle	Meiden Sumam	Jan Jan	nely
	Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryla to f Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f shoy or other treumatic event, the Madical Examinational be notified at	9 Be	4	suport			Touch	٧.	lon	7	,
	<u> </u>	2 should be and Mental is marked o	2	19a. Informant's Name/Relationship (19b. Mailin	Address (Street and	Number or Rura	I Route Numb	er, City or Town,	State, Zip	Code)
		and 2: ealth ar n 27 is		WILLIE Griffin	/ NUSBAND	2116	Bradd:	I N Avo	Balt	ines h	4 -	12/6
	altimore,	s 1 a of Hea item	i	20a. Method of Disposition	Ca	ace of Dispos	ition (Name of atory or other place)	-27	ate /10	20c. Location -	City or To	wn, State
	Ē	Page nent c		1 Surial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Special	n/ Ban	rison	Fores & U. A	Comble	ing	Owines	MI	15, My
	alti	permit. Pages 1 a Department of He Important: If item any injury or othe		21. Signature of Funeral Serv C. Luce	see	22	Name and Address of	Facility (MTM.	m-/Jar	111	Engel Har
	<u> </u>	205 20	()	23a. Part1. Enter the disease, or com	Usi	B	of to mail	led ordi	11-		-	
•		Physician /Medical Examiner		shock or hear failure. List only immediate Cause (Final disease or conditionesulting in death)	a. Due to (or as a consequence)	ence of):	lasculu	AC	Cicle	ent		Approximate Interval Between Onset and Death
	,8760,	cate be executed oblysician and the burial-transit	dicai Examiner	Sequentially list conditions, It any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c							
	P.O. Box 6	To the Hospitel or Attending Physicien: The law requires that the death certific: within 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending pl completely filled in by the funeral director, page 2 should be detached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⊉ No 9 □ Unknown	23c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)			23d. Dai Mo	te of delive	ry Day Year
	Division of Vital Records, P.	signed by	ρ	Part II. Other significant conditions of	contributing to death but not resu	ilting in the ur	derlying cause given in	Part I.		obacco use cont Yes 2 \(\subseteq No	ribute to th	e cause of death?
	Ö	w require been si should b	Completed	150	mentra				24a. Was	an 24b. \	Were autor	osy findings available inpletion of cause of
	Re	sician: The law certificate has t irector, page 2 s	шо		7.1.				auto perfo	ormed?	orior to con death? I 🔲 Yes	
	ta	an: 1 tifical tor. p	0	25. Was case referred to medical			26	. Place of Death			1 103	25 140
	\S	Physician: r this certifica ral director, p	To B	examiner? 1 ∐ Yes 2∯No	Hospital: 1 Inpatient 2 I	ER/Outpatien	3□ DOA Other:	4 Nursing Hor	ne 5□Resi	dence 6 □Oth	er (Specify)
	0	ng Pt fter th		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	1	28d. Describe	how injury occurr	ed	
×	Sio	tendi leath. Ior: A the fu	cati	2 Accident investigation 3 Suicide 6 Could not be				2 🗆 No	206 Lanation (C44 4 8 /		1 Courte Missonhar
	Ν	or At after d Direct in by	Certification:	4 Homicide determined	28e. Place of Injury - At hor building, etc. (Specify	me, farm, stre	et, factory, office	1	City or To	Street and Numb wn, State)	er or Hura	Houte Number,
		To the Hospitel or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	edical Co		nysician: To the best of my know miner: On the basis of examinat and manner stated.							
_		omple	Med	29b. Signature analytitle of certifier	(a () 10h	^	29c. License nu	mber		29d. Date signe	d (Month, i	Day, Year)
		- > - 0		Della At	tunum filly	vera.	1 05	3642	2	Marc	G f	2004
		3		30. Namer and address of person who	completed cause of death (Item	23a) (Type.		P 303	3 Ba	(+mr	e .	21239
		Sta Regist		31. Date filed (Month, Day, Year) WAR 1 9 700	2. Registrar's Signat	ture	E)					

			1 For	State of Maryland /	Depa	rtment of H	lealth and M		ene		000:-
			1 - State Registrar		Cer	tificate of	Death		3	04	08847
	Physici	an	Decedent's Name (First, Middle, Last) BARNET	ГТ		GLASSBER) C	2. Date of Death Month	_	Year	3. Time of Death
	/Medi Examir		4a. Fecility Name (If not institution, give s		-		r Location of Death		4c. County of	of Death	5:00 A M
	Examir	ier	5502 HARRIS FARM		ľ	-b. Ony, Town, or	CLARKSV		40. County (OWARD
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last t	birthday)	If Under 1 Year	If Under 24 Hrs.		(225)	9. Birthota	ice (State or Foreign
	Director		113-20-3020	M 2□F 94	Yrs.	Months Days	Hours Min.	JUNE 13,	1909	Countr	NY NY
	and w		Usuel Residence of Decedent 10a. State 10b. County	10c. City, To	wn or Lor	ation				10	d. tnside City Limits
	f sho	20	MD HOWARI			KSVILLE					1 ☐ Yes 2 ☑ No
	28a-	Director	10e. Street and Number	J	CLARI	10f. Zip Code		10	g. Citizen of W	hat Countr	
	hours after death with the Maryland tural', or Items 23a or 28a-1 show al Exentrals be notified at	i Di	5502 HARRIS FARM L	LANE			21029				I.S.A.
	deat	Funeral	11. Marital Status	2. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No	13. W	/as Decedent of H	ispanic Origin? (Sp in, Mexican, Puerto	ecity Yes or No-		- America	n Indian,
9	or It	y Fu		1 Tes 2 No	1	Yes 2X No	Specify:	rican, etc.)	Specify:	, White, et	ic. HITE
5-0036	hours tural'	ed by	3 Widowed 4 Divorced	Year or Dates:							
5	within 72 ene. thsn "nai	Completed	15. Decedent's Educ (Specify only highest grade	completed)	(Give k	ent's Usual Occupa ind of work done of ONOT use retired	ation during most of work I)	ring	6b. Kind of Bus	iness/Indu	stry
212	d with	mo:	Elementary/Secondary (0-12)	College (1-4or 5+) 5+ /	ATTOR				AT LAW		
פ	be filed within 72 hours tal Hygiene. d other then "natural", event. It e Modical Exe	Bec	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, Ma	iden Sumame)	
<u>yla</u>		70	HARRIS		GLASS	BERG	FANNIE		(U)	NOBTA	INABLE)
Maryland	s 1 and 2 should I Health and Mer Item 27 is marke othar traumatic		19a. Informant's Name/Relationship (Typ					al Route Number, (
	1 and Health em 2 thar t		PAULINE GLASSBERG 20a. Method of Disposition					- CLARKS	VILLE,		
altimore,	0 = 0		1 X Burial 2 ☐ Cremation 3 X Re 1 4 ☐ Donation 5 ☐ Other (Specify)	MINOVALI NUMI SLAME		ition (Name of atory or other place					
	nit. Pa artmen ortant: injury		21. Signature of Funeral Service License			T CEMETE Name and Addres		The second secon	FARMING		
ä	Dep imp gny		Day (May)	Levi	89	OO REIST	EBSTUMN E	LEVINSO	KECATII N & RKC)S., .	INC.
Н			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	cations that caused the death. Do						A	Approximate nterval Between
1	Physician		tmmediate Cause (Final disease or condition	Senara						Ö	Onset and Death
	/Medical Examiner		resulting in death)	Due (or as a consequence	e of)		0 .	•			
	CXAIIIIIIEI	L	Sequentially list conditions, b.	Munary	1/2	out a	relect	in			
	ped tist	nine	Cause (Disease or injury that initiated events	Due to (or as a consequence	e of):	71,0	goil.	Mot.			
	be executed sicien and burial-transit	Examiner	that initiated events c. resulting in death) Last	Due to (or as a consequence	g of):	va	ywn1	recurro			
/60	te be e ysicien le buria	calE	d	Uthe rosel	lra	tic lo	udiova	escula	1 Klu	was	e l
		ed	0.						7 - 0		
X R O	death certifica e attending ph d for use as th	ian/M	230. Was decedent pregnant	lc. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal deat	th 3∏f	ctopic pregnancy			23d. Date	,	
	e dea the at	Physici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of death 9☐Unknown		Other (specify)			Mont	h Da	ay Year
J.	requires that the death certifica leen signed by the attending ph hould be detached for use as th		Part II. Other significant conditions conti	obuting to death but not regulting	in the unc	loshing on uso awa	on in Clark I	220 Did tohou)	usta ta tha	cause of death?
Kecords,	w requires that s been signed b should be deta	d by	Almentia	nothing to dealify but not resulting	in the one	leriying cause give	ni ili Faiti.		2 □ No 3		30
Ö	> 40 70	Completed	Anemia 14	all soid	10,	10000		24a. Was an			
	ha:	шс	- oranica of	Comme	200	<i>HERRY</i>)	autopsy performe	Dri	or to comp ath?	y findings available letion of cause of
	ician: Th certificate rector, pag	0	25. Was case referred to medical				26 Place of Death	1 ☐ Yes 2 ☐ (Check only one)	[No 1	Yes 2	□No
>	Physician: this certific	To B	examiner? 1 Yes No	ospitat:	utpatient	3□ DOA Othe		me 5 Residence	e 6 🗆 Other	(Specify)	
n or	ding Physician: h. After this certific funeral director,		27. Manner of Death 1 Natural 5 ☐ Pending		Time of Injury	28c. Injury Work	at	28d. Describe how			
sion	tendi leath. lor: A the fu	cati	2 Accident investigation 3 □ Suicide 6 □ Could not be				'es 2 □No				
$\frac{1}{2}$	or At after d Direct in by	Certification:	4 Homicide determined	28e. Place of Injury - At home, f building, etc. (Specify)	arm, stree	t, factory, office		28f. Location (Stree City or Town, S	et and Number State)	or Rural A	oute Number,
_	e Hospital or Atten 124 hours after deatl ie Funeral Director: letely filled in by the		29a. Certifier To Certifying Physic	cien: To the best of my knowled	e death	accurred at the lim	o date on it dans	and from the three many	odel and man		
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After com letely filled in by the funeral process.	edical	(Check only 2 Medical Examine one)	er: On the basis of examination at and manner stated.	nd/or inve	stigation, in my op	inion, death occurr	ed at the time, date	and place, and	d due to th	e cause(s)
	To trocom	Σ	29b. Signature and title of certifier	. //	4 0	29c. License	number	29d	Date signed (Month, Da	y, Year)
Ì.			> perns Nel	h Her n	7.0	1)4:	3899	71	and	117	,2004
	3		30. Name and address of person who com	p ted cause of death (Item 23a)	(Туре, Р	2		: M - M	71.1	1	1 4
			31. Date filed (Month, Day, Year)	22. Registrar's Signature	1	1. 11. Di	Dogr	11110	4A10.	4	1978 CH
	Sta Registra		MAR 1 9 2004	Doz. Hagistiai's Signature	pod		J			/	

No. Second policy Name 1 Property Name	004 08848
Special Special Special Number 15 Sex 15 S	2009 4130 AM
100 100	9. Birthplace (State or Foreign Country) Mary land
17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Masiler Summer) 19. Maining Address (Streat and Number or Rural Route Number, City or Town, State, Zp. C. Location, City or Town, State, Zp. C. Lo	10d. Inside City Limits
17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Masiler Summer) 19. Maining Address (Streat and Number or Rural Route Number, City or Town, State, Zp. C. Location, City or Town, State, Zp. C. Lo	L. S.A., Race - American Indian,
17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Masiler Summer) 19. Maining Address (Streat and Number or Rural Route Number, City or Town, State, Zp. C. Location, City or Town, State, Zp. C. Lo	ocity: Black
To ame S E. Hall Joannes E. Hall Johnson tory	
200. Method of Disposition Date D	
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. 1	on - City or Town, State
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, immediate Cause (Final disease are condition) resulting in death) Part III of the significant conditions a consequence of): Part III of the significant conditions on the part 12 months? 23d. Date of delivery months are significant conditions on the part 12 months? 23d. Date of delivery months are significant conditions on the part 12 months? 23d. Date of delivery months are significant conditions on the part 12 months? 23d. Date of delivery months are significant conditions on the part 12 months? 23d. Date of delivery months are significant conditions on the part 12 months? 23d. Date of delivery months are significant conditions on the part 12 months? 23d. Date of delivery months are significant conditions on the part 12 months? 23d. Date of delivery months are significant conditions on the part 12 months? 23d. Date of delivery months are significant conditions on the part 12 months? 23d. Date of delivery months are significant conditions on the part 12 months? 23d. Date of delivery months are significant conditions on the part 12 months? 23d. Date of delivery months are significant conditions on the part 12 months? 23d. Date of delivery months are significant conditions on the part 12 months? 23d. Date of delivery months are significant conditions on the part 12 months? 23d. Date of delivery months are significant conditions on the part 12 months? 23d. Date of delivery months are significant conditions on the part 12 months? 23d. Date of delivery months are significant conditions are consequence of): The part 12 months are significant conditions are consequence of): The part 12 months are significant conditions are consequence of): The part 12 months are significant conditions are consequence of): The part 12 months are significant conditions are consequence of): The part 12 months are significant conditions are consequen	
The property of the property o	Approximate Interval Between Onset and Death
FFEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetel death 4 Pregnant at time of death 5 Other (specify) 23d. Date of delivery Month Directory of the past 12 months? 1 Live birth 2 Fetel death 4 Pregnant at time of death 5 Other (specify) 24a. Was an autopsy performed of earth? 25b. Was case referred to medical examiner? 25b.	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the 1 Yes 2 No 3 Probable 24a. Was an autopsy performed a	
24a. Was an autopsy performed? 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No 26. Place of Death (Check only one) 27. Manner Death 1 Was unity or performed? 1 Yes 2 No 28. Place of Injury 28. Injury at Work? M 1 Yes 2 No 28. Location (Street and Number or Rural Rulling) 28. Place of Injury At home, farm, street, factory, office 28. Location (Street and Number or Rural Rulling) 28. Place of Injury At home, farm, street, factory, office 29. Certifier (Check only one) 29. Signature and title of certifier 29. Date signed (Month, Day 29.) 20. Da	
Continued by Property of the property of the	b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 2 10
Continued by Property of the property of the	Other (Specify)
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signature and title of certifier (Machine) 29c. License number 29d. Date signed (Month, Date)	
(Check only one) (Check one) (Check only one) (Check only one) (Check only one) (Check only one) (Check one) (Check only one) (Check only one) (Che	
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Date of Control of Contro	
March 1 March 1 March 1 March 1 March 1 March 1 March 1	
30. Name and address of person in Completed Cause of deal (1996, 1911)	11 1,2004
State 31. Date filed Marty, Day, Year) 32. Registrar's Signature	Care Center

4	•	For State Registrar	State of Maryl	and / Department of H Certificate of L	ealth and Mental Hy Death	giene 200	08849
Physi /Med		1. Decedent's Name (First, Middle	NICOLE	HASLUP	2. Date of D Month Febru	eath Day Year	3. Time of Death
Exam Funera Directo	niner > al	4a. Facility Name (If not institution Greater Balti 5. Social Security Number	more Medical	4b. City, Town, or Center Tows yrs. last birthday) If Under 1 Year Months Days		4c. County of Deal Baltime inth lay, Year) 9. Bin Co	
ore, Maryland 21215-0036 or 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If items 27 is marked other than "natural", or items 23a or 28a-1 show or other traumatic swent, in Medical Examiner transities multilied at	To Be Completed by Funeral Director	10e. Street and Number 2	12. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 1's Education st grade completed) College (1-4or 5+) Michael hip (Type, Print) 3 Removal from State	in U.S. 13. Was Decedent of Hi If Yes, specify Cubai 1 Yes 2 No 16a. Decedent's Usual Occupa (Give kind of work done of life. DO NOT use retired) HASLU 19b. Mailing Address (Street)	spanic Origin? (Specify Yes or Nn, Mexican, Puerto Rican, etc.) Specify: ation furing most of working No NC 18. Mother's Name (First, Middle Number or Rivial Route Num Date (10g. Citizen of What Co US A 10- 14. Race - Ame Black, Whit Specify: 16b. Kind of Business W / H e, Maiden Surmarne) ANNE	10d. Inside City Limits 1 Yes 2 No puntry? Incan Indian, e, etc. Indiatry Taige Zip Code) 10 2/204 Town, State
Baltimore Saltimore Saltim	n al	21. Signature of Funeral Service 23a. Part 1. Enter the disease, or	complications that caused the only one cause on each line. a. Due to (or as a core)	death. Do not enter the mode of dying Prewater has a sequence of):	K RD MONKTON	JENFINS + SON J MD ZILLI	
	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a cor c. Due to (or as a cor d.	nsequence of):			
Vision of Vital Records, P.O. Box 68760, Attending Physician: The law requires that the death certificate be executed actor: After this certificate has been signed by the attending physicien and by the tunist director, page 2 should be detached for use as the burial-transit	d by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown Part II. Other significant condition	23c. If yes, outcome of pr 1	Fetal death 3 Ectopic pregnancy	en in Part I. 23e. Dic	23d. Date of de Month I tobacco use contribute to	Day Year
Vital Recor	Be Completed	25. Was case referred to medica examiner?	Hospital:		per 1 ☐ Yes 26. Place of Death (Check only	opsy prior to death? 2X No 1 ☐ Yes	utopsy findings available completion of cause of 2 No
Division of Vital Records To the Hospital or Attending Physician: The law requires within 24 hours after death. To the Funeral Director: After this certificate has been sign completely filled in by the funeral director, page 2 should be	Certification: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pendir 2 Accident invest 3 Suicide 6 Could 4 Homicide detern	28a. Date of Injury (Month, Day Yea	M 1 □	yat 28d. Describe X? Yes 2 \[\] No	sidence 6 Other (Spe a how injury occurred (Street and Number or Rown, State)	
Division To the Hospital or Attent within 24 hours after dealt To the Funeral Director: completely filled in by the	Medical C		Examiner: On the basis of exa and manner stated.	y knowledge, death occurred at the tim mination and/or investigation, in my of 29c. License	pinion, death occurred at the time		e to the cause(s)
y . B		30. Name and address of person	who completed cause of death	(Item 23a) (Type, Print)	es St., Balt.	ma/ 21	204
	State istrar	31. Date filed (Month, Day, Year, MAR 1	9 2004 32. Registrar's S			المن نانانا	<i></i>

DHMH 17 Rev 1/2001

ORIGINAL

Dhysisi	3 p	1. Decedent's Name (First, Middle, Las							2. Date of Dea		Year	3. Time of Dea
Physici /Medic		Jean Elizabet							February		2004	11:15p
Examin	er	4a. Fecility Name (If not institution, give Sunrise Assisted					m, or Location Columb:				y of Death ward	
uneral irector		Social Security Number 6. Se	7. Ag	e (In yrs. Ia 75	st birthday) Yrs.	If Under 1 Y		r 24 Hrs. Min.	8. Date of Birt (Month, Da Aug 10		_	lace (State or Fo
ahow	_	Usuel Residence of Decedent 10a. State 10b. County	1	10c. City,	, Town or Lo						1	0d. Inside City L
or 28a-f	Funeral Director	MD Howar				10f. Zip Cod		ity		10g. Citizen of		1 Yes 2
18 23e	erall	7608 Stony Creek	Lane 12. Was Decedent	Eugs in 11 S	12.1		21043	ining (Sec	- it. Van aa Na	USA	ce - Americ	on Indian
than "naturel", or liems 23e or 28e-t ahow the Medical Ezandracimusi be notified at	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Amed Forces? 1 Yes 2 J If Yes, Give A Year or Dates:			f Yes, specify (ecify Yes or No- Rican, etc.)		ack, White, by: White	etc.
than "natur to Medical I	Completed	15. Decedent's Ed (Specify only highest grade Elementary/Secondary (0-12)		5+)	(Give life. I	lent's Usual Ockind of work do DO NOT use re	one during mo: atired)	st of worki	ing	16b. Kind of E		dustry
ther th		12 17. Father's Name (First, Middle, Last)			Но	memake:			(5)		stic	
p p	To Be	Willard Willi		ver	405 44 35		E	Eliza	beth Ru	eter		
27 is r trau		19a. Informant's Name/Relationship (7 Mr. Mark Hass (So	• • • • •		10604	Persi	nmon Ct	., L	aurel,	MD 2072	23	
ant: If item ury or othe		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify				sition (Name of natory or other y Crema			2004	Sykesv		
Important: If i any injury or once.		21. Signature of Funeral Service Licens	Hair !	+	HŽ	ighi fi ykesvi	UNERAL 11e, MI	HOME	& CHAP 84 (410	EL, PA)-795-1	(Box 400	195)
/sician ledical aminer		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)	a. Due to (or as	9 S)	atio	er the mode of		e cardiac o	CPV	rest,		Approximate Interval Betwee Onset and Dea
physician and s the burial-transit	dicai Examiner	rr any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as c. Due to (or as d									
ned by the attending placed for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes ②■No 9 ☐ Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant at 9□ Unknown	2 Fetal o	death 3	Ectopic pregna Other (specify					ate of delive	ry Day Yea
been signed the should be det	by	Part II. Other significant conditions co	ntributing to death b	ut not resul	ting in the ur	derlying cause	given in Part I	l. 	23e. Did to			e cause of deat ably 4 □Unki
ate has	Completed								24a. Was a autops perfor	sy med?	prior to con death?	esy findings ava appletion of caus 2 No
certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:				0.1		(Check only or			
ar this eral di	7: To	1 ☐ Yes 2/2(No 27. Manner of Death	28a. Date of Inju	ry 2	R/Outpatient 28b. Time of	3 DOA	njury at		ne 5 Reside)
To the Funeral Director: After this certifics completely filled in by the funeral director,	Certification:	Anatural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined	(Month, Day 28e. Place of Inju	ury - At hom	Injury 18, farm, stre	M 1	Work? □ Yes 2 □	No	28f. Location (S	treet and Numi		Route Number,
neral Dir y filled in		29a. Certifier 1/2*Certifying Phy	building, etc	of my know	ledge, death	occurred at the	e time, date an	nd place, a	City or Tow	auco/s) and m	anner as sta	ated.
the Fu	ledical	one) 2 Medical Exam	iner: On the basis of and manner sta	examination	on and/or inv	estigation, in m	y opinion, dea	th occurre	ed at the time, d	ate and place,	and due to	the cause(s)
To COM	Σ	29b. Signature and title of certifier	A				ense number 35a			3 -)	d (Month, E	Day, Year)

		For State Registrar	State of Maryla		artment of h			giene Reg. No 2004	08851
Physicia	an	1. Decedent's Name (First, Middle, Last)					2. Date of Dea	ath Day Yeer	3. Time of Death
/Medic Examine	al	Reba May Harris 4a. Fecility Name (If not institution, give si			4b. City, Town,	or Location of Death	MARCI	4c. County of Dee	
CXanini	EI	MARTNER HE			BE	L AIR		HARF	
Funeral Director		5. Social Security Number 6. Sex 1 - 20 - 6440	M 2 F 7. Age (In yrs	. last birthday) Yrs.	Months Days		8. Date of Birt (Month, De Jan. 26	y, Year) 9. Bir Co. 1923 Vi	thplece (State or Foreign buntry) LGLNLA
		Usuel Residence of Decedent 10a, State 10b, County	10c. C	ity, Town or Lo	cation				10d. Inside City Limits
Maryla Ind al	tor	Maryland Harford			l Air				1 ☐ Yes 2 ☑ No
or 288	Funeral Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What Co	ountry?
leath w	eral	700 Chambers Circ	2. Was Decedent Ever in	U.S. 13. V		21014 Hispanic Origin? (Sp	ecify Yes or No	U.S.A. 14. Race - Ame	
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene, the maryland with the natural; or items 23s or 28s-f show ont, the Medical Examiner must be multified at	by	1 Never Married 2 Married 3 💢 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		f Yes, specify Cub	Hispanic Origin? (Sp pan, Mexican, Puerto Specify:	Rican, etc.)	Black, Whit	
15-00%	leted	15. Decedent's Educ (Specify only highest grade		(Give	lent's Usual Occu kind of work done DO NOT use retire	during most of work	ing	16b. Kind of Business	/Industry
212- d withir giene. or then	Completed	Elementary/Secondary (0-12) 12th Grade	College (1-4or 5+)		nemaker			Own Home	
	Be	17. Father's Name (First, Middle, Last) Charles Edward	Byram					Maiden Sumame) Beth Smit	h
arylan, should be nd Mental in marked o	^L	19a. Informant's Name/Relationship (Typ		19b. Mailir	ng Address (Street	J		er, City or Town, State,	
and 2 eath a m 27 ls		Mr. Edwin S. Harri				Circle, E			
norte		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Re	BITTOVAL ITOHI STATE		sition (Name of natory or other pla	1	Date	20c. Location - City or	
Baltimore permit. Pages t Deparatment of t Important: if ite any injury or ot		* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensa		viaens (Name and Addr	ess of Facility Sch	rimunek	Baltimore, Funeral Ho	nes
W FOFFE		Bui Ce Ul	lle		9705 Be	lair Rd.,	Baltimo	re, MD 21	236 Approximate
Physician /Medical Examiner		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each line. CHRONIC Due to (or as a conse	REN	AL FA	CLURE		1651,	Interval Between Onset and Death
- The state of the	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	- 10:	1	SISEASE			
60, be executed sician and burial-transit	Examin	Cause (Disease or injury that initiated events cresulting in death) Last	Due to (or as a conse	equence of):	N				
58760, cate be exphysician as the burial	edical	d							
P.O. Box 68760, that the death certificate be executed ed by the attending physician and detached for use as the burial-transi	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of preging the first series of the first seri	tal death 3	Ectopic pregnand Other (specify)	ey		23d. Date of de Month	livery Day Year
IS, P.O. Is, P.O. Is that the designed by the 2 be detached 1		Part II. Other significant conditions con	tributing to death but not re	sulting in the u	nderlying cause gr	ven in Part I.	23e. Did to	obacco use contribute to	the cause of death?
I 2 2 2 2 2	ted b	CONGESTIVE	HEART	AILL	1RE		101	Yes 2□No 3□P	obably 4 Unknown
I Rec	Completed by						24a. Was autop perfo 1 Yes	rmed? death?	utopsy findings available completion of cause of
A Vital F of Vital F Physician: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital:	□ FR/Outpatien	t 3 DOA Ot	26. Place of Deat		dence 6 □Other (Spe	cify)
		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yeer)	28b. Time of Injury	28c. Inju			now injury occurred	,
Price Rendered Spital or Attending ours after death. Silled in by the fune filled in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm, str cify)	eet, factory, office		28f. Location (S City or Tox	Street and Number or Ri vn, State)	ural Route Number,
Divi	edical (29a. Certifier 1 Certifying Phys (Check only one)	sician: To the best of my kner: On the basis of examinand manner stated.	nowledge, death nation and/or in	n occurred at the t vestigation, in my	ime, date and place, opinion, death occur	and due to the red at the time,	cause(s) and manner as date and place, and due	s stated. to the cause(s)
To the Hosp within 24 ho To the Func	Me	29b. Signature and title of certifier			29c. Licen	se number		29d. Date signed (Mont	h, Day, Year)
_\^		▶ Withhis	gufar M)	1 23	5017		MARCH 17,	2004
V		30. Name and address of person who	mpleted cause of death (Ite HYANKAZ	em 23a) (Type,	Print) NORTH	AVENUE	BEC	AIR a	12/0/4
Sta Registr		31, Date filed (Month, Day, Year). MAR 1 9 20	32. Registrar's Sign	nature	backs				,

		4	1 - For State Registrar	State of Marylan		artment of He			giene Zeg. No. 2	004	08852
	Physici /Medio	al	Decedent's Name (First, Middle, Las CARL LEE H 4a. Facility Name (If not institution, give	ARRISON J	٤.	4b. City, Town, or		2. Date of Dea Month	Day	Yeer 2004 Inty of Death	3. Time of Death 8'50 AM
	Examin Funeral Director	er	908 CENINE DE 5. Social Security Number 6. St 218-35-7242	IVE	last birthday) Yrs.	GLEN B If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.		ANN	EARU	NOCL lace (State or Foreign try)
	hours after deeth with the Maryland turer, or ttems 23e or 28e-f show at Exercited at the colified at	ector	Usual Residence of Decedent 10a. State 10b. County Arward AR	under Ch	y, Town or Lo	URNIE			10-03		0d. Inside City Limits 1 ☐ Yes 2 ☑ No
	deeth with t	Funeral Director	10e. Street and Number 908 GENINE 11. Marital Status	12. Was Decedent Ever in U.	.S. 13.	10f. Zip Code 2 C	spanic Origin? (S	pecify Yes or No-	<u>()</u>	of Whet Coun	an Indian,
-0036	hours after sturet, or ite	ρ	1 Never Married 2 Married 3 Widowed 4 Divorced		3 16a. Dece	f Yes, specify Cuban	Specify:		Spe	Black, White, of Business/Inc	ITE
121215-0036	s 1 and 2 should be filed within 72 hours after deeth with the Marylan if Health and Mental Hygiene. Item 27 is marked other then "natural", or items 23a or 28a-1 show other traumatic event, it.e Medical Examinational Controlling at	Completed	(Specify only highest gra Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last)	College (1-4or 5+)	(Give	kind of work done di DO NOT use retired) RIVER	uring most of wor	king ne (First, Middle,	TRAN	ISPORT	ATION
Maryland	should be to nd Mental by marked of umatic ever	To Be	CARL LEE HARRIS	on sr.	50b Mailie	ng Address (Street a	CITA MA	RIERI	ر 2 <i>55</i> د)	Codel
	1 and 2 sho Health and Iem 27 is m		JENNIFER M. FREY 20a. Method of Disposition	DAUGHTER 200. P	9036	ENINE DR sition (Name of	IVE GIEA	BIRNE Date	MD.	ZIOE on - City or To	20
Baltimore	Page ment o ant: M ury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Fureral Service Licen	BA	NIEW	REMATOR Name and Address	4 3-1	9-04 1	BALTIN	DORE, I	MD.
Ba	Departi Departi Importi any inji		23a. Parl. Enter the disease, or rom			Daugherty Fa 2601.1	amily Funeral I Mountain Road	lome And Cren - Pasadena,	MD. 21122		Approximate
To the second	Physician /Medical		shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a conseq	NA	ticli	nge (and	~		Interval Between Onset and Death
ije.	Examiner	ier	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequence of the consequence o							
8760,	ate be executed obysician and the burial-transit	ical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a consequ	uence of):						
Ö	death certificate e attending phys d for use as the	/Medic	IF FEMALE:	23c. If yes, outcome of pregna	nev	740					
P.O. Box	that the death led by the atten detached for u	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of di 9 ☐ Unknown	I death 3	Ectopic pregnancy Other (specify)			1	Date of delive Month	ry Day Year
Records, I	law requires that the as been signed by th 2 should be detache	þ	Part II. Other significant conditions of	ontributing to death but not resi	ulting in the u	nderlying cause give	n in Part I.		obacco use c ′es 2□No		e cause of death?
al Reci	The ate h	e Completed	25. Was case referred to medical						sy med? 2 X No	prior to con death?	osy findings available npletion of cause of 2 No
of Vital	S 0 0	To Be	examiner? 1 ☐ Yes 2 No		ER/Outpatien	Other		th (Check only of		Other (Specify)
Division o	Attending Physicien: r death. ector: After this certific by the funeral director,	ation;	27. Manner of Déath 1 Natural 5 ☐ Pending 2 ☐ Accident investigation		28b. Time of Injury	28c. Injury Work! M 1 TY	at ? ′es 2 □ No	28d. Vescribe h	ow injury oc	curred	
DIVIS	i Sir e	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, str y)	eet, factory, office		28f. Location (S City or Tow	itreet and Nu n, State)	imber or Rural	Route Number,
	To the Hospitel within 24 hours a To the Funeral I completely filled	Medicai	29a. Certifier Certifying Ph (Check only one) Certifying Ph	ysician: To the best of my kno niner: On the basis of examina and manner stated.	wledge, death tion and/or in	occurred at the time restigation, in my opi	e, date and place inion, death occu	, and due to the or rred at the time, o	ause(s) and date and plac	manner as sta ce, and due to	ated. the cause(s)
	To the within 2 To the comple	M	29b. Signature and title of certifier	M		29c. License	number (4197	7	29d. Date sig	ned (Month, L	Day, Year)
	'Χ		30. Name and address of person who	completed payse of death (Item	n 23a) (Type,	Print)	11 to	D R	DI	A . NA	021102
	Sta Registi		31. Date filed (Monto, Day, Year) MAR 1 9 2004	32. Registrar's Signa	iture	books		1 - 10	10.00	46	y will

State of Maryland / De

partment of Health and Ment	al Hygiene
Pertificate of Death	2004

08853 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2004 March 15, Year **Physician** JOHN STEVEN 01:05 PM HUDSON /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 41 Lerner Court Parkville Baltimore 8. Date of Birth (Month, Day, Y)
Dec. 13, 5. Social Security Number 6. Sex 1X M 2□ F If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year) Months 217-08-7979 31 Director 1972 Maryland Usual Residence of Decedent filed within 72 hours after deeth with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits or 28a-f show event, the Medical Examiner must be notified at Baltimore 1 ☐ Yes 2 No Maryland Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 41 Lerner Court or Itema 23a 21236 Completed by Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: 3 ☐ Widowed 4 ☐ Divorced White Year or Dates: "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If tem 27 ie marked other than "na any injury or other traumatic avantation." Elementary/Secondary (0-12) College (1-4or 5+) 12 years Warehouse Worker Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Alfred Hudson ပ Martha Georgia Kistner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ray Hudson (brother) 265 W. 31st. Street Baltimore, Maryland 21211 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Moreland Memorial Park 3-19-04 Baltimore, Maryland Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland 21. Signature of Funeral Service Licensee leon 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Multiple **Physician** Snav /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed the attending physician and ned for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown signed by Part II. Dther significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown been 24b. Were autopsy findings available prior to completion of cause of death?

1 ★ es 2 □ No 24a. Was an certificete has autopsy performed? 1X Yes or Attending Physician: 25. Was case referred to medical examiner?

1X Yes 2 □ No Be 26. Place of Death Check on one Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred and cut seff 28b. Time of 28c. Injury at Work? After 1 Natural Injury 5 ☐ Pending 3/15/2004 12:10 VM 12 28 Place of Injury - At home, farm, street, factory, office building, etc. (Specify) death. investigation 1 ☐ Yes 2 X No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) home Lerner Ct. ParkvilleMD Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

**Commonship Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) the O.C.M.E. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) March 16, 2004 berg reen 30. Name and address of person who completed cause of death (kem 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 Iasha Z Gueenberg 31. Date filed (Month, Day, Year)

State

Registrar

MAR 1 9 2004

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** COPM < 200 12 law /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner rudle Jack 15V1(If Under 24 Hrs. P ommons 0 TIMORE 5. Social Security Number 6. Sex (In yrs. last birthday, 7. Age Date of Birth Birthplace (State or Foreign (Country) **Funeral** Months Days Hours Min. 6850 1 M 2 XF **Director** irainia Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits , or Items 23a or 28e-f show the Medical Examiner must be notified at 1 Yes 2 □ No Director Varyland nore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 225No Specify: ል Slac 3 X Widowed 4 □ Divorced "neturel", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be fill ment of Health and Mental Hient; if item 27 is marked ott 19a. Informant's Name/Relationship (Type, Print daughter) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Importent; If item 27 is any injury or other trau <u>once</u>. HOIME < 21216 zera 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 □Removal from State ' 4 Donation 5 DOther (Specify) Wood 21. Signature of Funeral Service Licenses 22 Name and Address of Facility Home ra AUQ. 23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on e aused the death. Do not enter the mode of dying, such a condiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Work /Medical Due to (or as a consequence of): Examiner arcinoma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner and al-transit To the Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): physician a Records, P.O. Box 68760. Completed by Physician/Medical attending p use as IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death signed by the a 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Junknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a Wasan 2 No Division of Vital 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3□ DOA After the funeral of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident the hours after deat 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide within 24 hours a To the Funerel (29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

State Registrar 30. Name and

of death (Item 23a) (Type, Print) LOC 31. Date filed (Month, Day, Year) MAR 19 egistrar's Signature

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			1 - For State Registrar	State of Maryland	/ Department <i>Certificate</i>		Mental Hygier		08855
,	Physici /Medi	cal	1. Decedent's Name (First, Middle, Las Jomes 4a. Fecility Name (If not institution, give	Ja	ckson	Town or Leasting of Deat	2. Date of Death	2 2004	3. Time of Death #4
	Examir Funeral Director	ner	5. Social Security Number 6. Se 220 - 22 / 210	l conter	birthday) If Under	Year If Under 24 Hrs Days Hours Min.		4c. County of Death CHY 9. Birth Cou 9.1 M H	plece (State or Foreign
ore, Maryland 21215-0036	es 1 and 2 should be filed within 72 hours after death with the Maryland of Heatth and Mental Hygiene. If item 27 ie marked other than "natural", or items 23a or 28a-f show ir other traumatic event, I'm Medical Examinat must be notified at	To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County 10b. Street and Number 827	10c. City, T 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Give Year or Dates: Ideation (e completed) College (1-4or 5+) 10c. City, T 11. Was Decedent Ever in U.S. Armed Forces? 1 Yes, Give Year or Dates: 1. Cation (e completed) 1. College (1-4or 5+)	own or Location Bibling 13. Was Deceded If Yes, specification 1 yes 26 6a. Decedent's Usual (Give kind of work life. DO NOT use) Thuck 1	ant of Hispanic Origin? (Street and Number or Ru	pecify Yes or No- o Rican, etc.) Tking The (First, Middle, Maidle) Trail Route Number, City Bull h Number	Citizen of What Cou USD 14. Race - Amen Black, White, Specify: Bk Kind of Business/In SULLARS en Sumame) y or Town, State, Zip	10d. Inside City Limits 10 Yes 2 □ No Intry? can Indian, etc. dustry Frerent Code)
Baltimore	Permit Pag Berment Important: Pag Constitution of the page of th	iner	*4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens 23. Part 1 Enter the disease, for comp shook, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	Lorre	22. Name and 52 (10) Property of the mode	Address of Facility CA	LUMB	OUDCHUS Mir son	Approximate Interval Between Onset and Death
Records, P.O. Box 68760,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the buriat-transit	Completed by Physiclan/Medical Examiner	that initiated events resulting in death) Last	Due to (or as a consequence of the consequence of t	ath 3 □Ectopic preg	city)	1 es	o use contribute to the 2 No 3 Prob	Day Year ne cause of death? nably 4 Unknown psy findings available
Division of Vital Re	To the Hospitel or Attending Physician: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Medical Certification: To Be Comp	27. Manner of Death Matural 5 Pending investigation	Hospital: 1 patient 2 ER/	farm, street, factory, of the farm, street, factory, of the farm, street, factory, of the farm, street, factory, farm, f	26. Place of Dea Other: 4 Nursing H 5. Injury at Work? 1 Yes 2 No office the time, date and place, a my opinion, death occur	autopsy performed; 1 Yes 2 1 th (Check only one) ome 5 Residence 28d. Describe how inj 28f. Location (Street a City or Town, Sta	prior to condeath? 1 Yes 6 Other (Specification of the condeath) and Number or Rurate) s) and manner as stand place, and due to	I Route Number, ated. the cause(s)
	Sta Registr	te	30. Name and address of person who co	impleted cause of death (Item 23a) 32. Registrar's Signature	a) (Type, Print)	301 SJ	Paul :	ate signed (Month, I	2009

			i icuoc					Health and	•	Are Legible.	
			1 - For State Registrar	Glate of M	iai yiai iu	-	tificate of			2001	08856
	_		Decedent's Name (First, Middle, L.)	ast)			imouto or	Dodin	2. Date of Dea	3	3. Time of Death
	Physici /Medio		Queen Ester Jac	obs					March	Day Year	> M
	Examin		4a. Facility Name (If not institution, gi	ve street and number)			- (.	or Location of Dear	th	4c. County of De	
				pital of		MOYE	It Under 1 Yea	r If Under 24 Hrs	City		
	Funeral Director		5. Social Security Number 6. 246–42–3122		ge (In yrs. Ias 73	Yrs.	Months Day			9. Bi	rthplace (State or Foreign Country) th Carolina
	ъ		Usuel Residence of Decedent						01/20/1	931 NOI	ch carorina
	arylar show	-	10a. State 10b. County		10c. City,	Town or Lo	cation				10d. Inside City Limits 1 X Yes 2 ☐ No
	the M	ecto	Maryland 10e. Street and Number		Balti	more	10/ 7:- 0-1-			0.0000000000000000000000000000000000000	
	with Sa or	Funeral Director	4583 Derby Mano	r Drivo			10f. Zip Code 21215			10g. Citizen of What C	ountry?
	death ms 23	nera	11. Marital Status	12. Was Decedent	Ever in U.S.	13. \	1.	Hispanic Origin? (S ban, Mexican, Puer	Specify Yes or No-		
9	or Ite	Fur	1 X Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 🔯 If Yes, Give			Yes, specify Cu ☐ Yes 2 No		to Rican, etc.)	Black, Wh	
8	be filed within 72 hours after death with the Maryland lat Hygleine. d other than "neturel", or Items 23e or 28e-f show svent, the Medical Executes traist be notified at	d by	3 Widowed 4 Divorced	Year or Dates:							
15-	n 72 in Completed	15. Decedent's E (Specify only highest g	rade completed)		(Give	lent's Usual Occu kind of work done OO NOT use retir	e during most of wo	orking	16b. Kind of Busines:	s/Industry	
212	with jene. r than	ошь	Elementary/Secondary (0-12)	College (1-4or :		Cashi		,		Retail Sa	les
ਰੂ	e filec al Hyg othe vent,	BeC	17. Father's Name (First, Middle, Las	t)		000112		18. Mother's Na	me (Fîrst, Middle,		
<u>yla</u> ı	Ments Ments arked	To	(unknown)					Luzenia	Jacobs		
Maryland 21215-0036	l 2 sh	0	19a. Informant's Name/Relationship							r, City or Town, State,	,/
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is merked other than "neturel", or Items 23a or 28e-f show early filtry or other treumatic svent, the Medical Examinating the nufficial at ODCs.		Andrew James Jac						Date	nore, Mary	
Baltimore,	ages ent of it: If it y or o		1 Burial 2 Cremation 3 \ '4 Donation 5 Other (Spec		1		sition (Name of natory or other pl	10372		Baltimore,	
票	mit. F partm porter / Injur	1	21. Signature of Funeral Service Lice		ALDU				Derrick	C. Jones	F/H, P.A.
m	Depa Impo eny I		Dent	C. J.							yland 21215
			23a. Part1. Enter the disease, or cor shock, or heart tailure. List only	nplications hat saused one cause on each li	d the death. ine.	Do not ente	er the mode of dy	ring, such as cardia	c or respiratory arr	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	-a Pre	UMOR	ia					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as	a conseque	nce of):					J
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. — Due to (or as	a conseque	nce of):					
	d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events								
Ó	te be executed ysician and ie burial-transit	Exa	resulting in death) Last	Due to (or as	a consequer	nce of):					
8760,		licai	•	d							
ox 68	ding p	Physician/Med	IF FEMALE:	23c. If yes, outcome	of program						
$\mathbf{\alpha}$	atten atten I for u	cian	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal de	eath 3	Ectopic pregnand Other (specify)	су		23d. Date of de Month	Day Year
o.	t the c by the achec	hysi	9 Unknown	9 Unknown							
S, D	The law requires that the death certifica tie has been signed by the attending ph bage 2 should be detached for use as th	by P	Part II. Other significant conditions	contributing to death b	out not resulti	ng in the un	derlying cause g	iven in Part I.	23e. Did tol	pacco use contribute t	the cause of death?
Record	w requir been sl should	ted	End - Stage	renal d	i sea	se 6	n hen	node alys	15 10 Ye	es 2.1¼TNo 3.∏.P	robably 4 Dunknown
ec ec	e law has b	Completed	Congestive	heart	fai	lune			24a. Was a autops	v prior to	utopsy findings available completion of cause of
			Diabetes M	ellitus					perform	ned? death? 21♥ No 1 ☐ Yes	2 0X No
Vita	hysicien: The la nis certificate ha: I director, page 2	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 🕱 Inpatie	ont 2015	VOutpatient	201	thor	ath (Check only on		
10	ding Phy h. After this funeral d	n; To	27. Manner of Death	28a. Date of Inju	ıry 28	3b. Time of	28c. Inju	ury at		ence 6 Other (Spe ow injury occurred	city)
lo	Attending Physicien: r death. sctor: After this certificiny the funeral director.	atlo	1 Natural 5 Pending 2 Accident investigation		y rear)	Injury		ork?]Yes 2 □ No			
Division of	l or Atter de after de Directo	Certification;	3 Suicide 6 Could not l 4 Homicide determined	28e. Place of Injuding, etc	ury · At home c. (Specify)	e, farm, stre	et, factory, office		28f. Location (St City or Town	reet and Number or R n, State)	ural Route Number,
	pitel c urs af erel D		One Continue 1 to Continue								
	To the Hospitel or Atten within 24 hours after deat to the Funerel Director: completely filled in by the	edical	29a. Certifier 1 \text{\text{\$\infty}\$ Certifying P (Check only one)} 2 \text{\$\infty}\$ Medicel Exe	hysicien: To the best miner: On the basis of and manner sta	t examination	and/or inv	occurred at the t estigation, in my	ime, date and place opinion, death occu	e, and due to the ca arred at the time, da	ause(s) and manner as ate and place, and due	s stated. e to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier				29c. Licen	se number	2	9d. Date signed (Mont	h, Day, Year)
	\cap		Cindy X	Huana	MI		PA	5 1902	7	March 1	6, 2004
	,4		30. Name and address of person who	completed cause of d	leath (Item 23	3a) (Type, F	1 . 1.1	1 1	Λ.	n fi	1.5
			31 Date filed (Man True Town	- ucing	ar's Signatur	2'	tol We	est Belo	edere	Baltimor	e MD 2/2/5
	Sta Registr	-	31. Date filed (MWARY, 1eag 2	004 September 1	ar a dignatur	1					

Queen Jacobs

			1 - For Unpend Item#2: Registrar	State of Ma la,Part II,27,Pe	aryland / Dep er ME,6829,3/	artment of F	Health and M Death	Mental Hyg	iene 2004	08857
	Dhusia		1. Decedent's Name (First, Middle					2. Date of Deat	h	3. Time of Death
	Physic /Medi		Haron	Joynes				March 1	4, 2004 Year	03:27 P.M
	Exami	ner	4a. Facility Name (If not institution				r Location of Death		4c. County of Deeti	1
7			1826 North Ave		(In yrs. last birthday)	Baltir		8. Date of Birth	NA	
3	Funeral Director		220-76-7645	1 M 2 □ F	45 Yrs.	Months Days	Hours Min.	Month, Day,	Year) 9. Birth	nplace (State or Foreign untry)
()			Usual Residence of Decedent					1,000,10,1	725 11414	rylana
	ehow	_	10a. State 10b. County	110	10c. City, Town or Lo	ocation				10d. Inside City Limits
	after death with the Maryla or Rems 23a or 28s-f ehor miner must be notified at	Director	10e. Street and Number	44	Balt	10f. Zip Code			0.00/	1 Yes 2 No
	23a or	io i	22 N/2 Piac	Imont 6	110	7/5	1/-	"	0g. Citizen of What Co	
	ter death	Funerai	11. Marital Stetus	12. Was Decedent E		Was Decedent of H	lispanic Origin? (Sp	ecify Yes or No-	14. Race - Amer	
98	or ite	y Fu	1 Never Married 2 Marri	Armed Forces? 1 Yes 2 N If Yes, Give	lo	If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	an, mexican, Puerto Specify:	Hican, etc.)	Black, White), etc.
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show ite Mudical Examinat must be notified at	ed by	3 Widowed 4 Divorced	Year or Dates:		/-			Specify: B	ack
7.	nin 72 he n "natur	Completed	15. Decedent (Specify only highes	t grade completed)	(Give	dent's Usual Occup kind of work done o DO NOT use retired	during most of work	ing	16b. Kind of Business/I	ndustry
212	d withir giene. er than	E	Elementary/Secondary (0-12)	College (1-4or 5	+)	abore,	r		Auto M	echanic.
pu	should be filed von Mental Hygie marked other timatic event,	Be	17. Father's Name (First, Middle, I	ast)			18. Mother's Nam	e (First, Middle, N	faiden Sumame)	
<u>~</u>	ould be Mental narked o	မ	George E	, Joynes	\$		Doro	thy (arnige	
Maryland	nd 2 sho aith and 27 is ma	1 1	19a. Informant ame/Relationsh	ip (Type, Prin (Fat)	her) 19b. Maili	ng Address (Street	and Number or Rui	al Route Number,	City or Town, State, Zi	ip Code)
ē,	He He		20a. Method of Disposition	Joyries	20b. Place of Dispo	osition (Name of	mont	Date 2	20c. Location - City or T	own, State
ê E		. 4	1 A Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		M+ 7	matory or other plac	^(a) 3/23	12004 1	nnedri	ino Mil
3altimore,	permit. Page Department of Important: If any injury or once.	1	21. Signature of Funeral Service L	icensee / / /	2	Name and Addres	ss of Facility	_	eu Save	one, mo.
_	Dep Per Per Per Per Per Per Per Per Per Per	N 2	Joseph	L' Ku	30/ 27	SEPH N	of the Ave	. Balt	al Home	216
			23a. Party. Enter the disease, or shock, or heart tailure. List of	omplications that daused inly one cause on each lin	the death. Do not ent e.	er the mode of dyin	g, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	- u.	ve Atheroscl	erotic Card	iovascular	Disease		Onsor and Doam
	Examiner				consequence of);					
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a	і соль ецие нсе of);		-	<u>.</u>		
	ecuter and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c						
8760,	ate be executed thysician and the burial-transit		Southly III Godiny East	Due to (or as a	consequence of):					
687	tificate being physicia	Physician/Medical	_	d						
Вох	eath certific attending p for use as:	m/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		Je			23d. Date of deliv	ery
. B	s death	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown		Ectopic pregnancy Other (specify)			Month	Day Year
P.O.	Attending Physician: The law requires that the death certific robath. robath. ector: After this certificate has been signed by the attending p by the funeral director, page 2 should be detached for use as	Phy	9 Unknown							
ds,	signe d be d		Part II. Other significant condition Chronic Alcoholism		t not resulting in the ui	nderlying cause give	en in Part I.		acco use contribute to t	
Sor	w requir been si should	ietec							s 2 □ No 3 □ Prol	
Division of Vital Records,	he lav e has age 2 :	Completed by						24a. Was an autopsy perform	prior to co	opsy findings available impletion of cause of
ta	sician: Th certificate rector, pag	Be C	25. Was case referred to medical	1			26. Place of Death			2 No
>	Physici this ce al direc	TOE	examiner? t xxx res 2 ☐ No	Hospital: 1 ☐ Inpatien	nt 2 ER/Outpatien	t 3 DOA Othe			nce 6 Prither (Specia	V) OF LINE
0 0	ing Pl	on:	27. Manner of Death 1 ■ Natural 5 □ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time of Injury	28c. Injury Work	at c?	28d. Describe how	v injury occurred	SCAME.
Sio	ttend death tor: A	cati	2 ☐ Accident investigated inve	ation	4.5		Yes 2 □ No			
Div	after after Direct In by	ertif	4 ☐ Homicide determin	building, etc.	ry - At home, farm, stre (Specify)	eet, factory, office		281. Location (Stre City or Town,	eet and Number or Rura State)	al Route Number,
	ospite hours inerely y fillec	alc	29a. Certifier 1 ☐ Certifying	Physician: To the best of	f my knowledge, death	occurred at the tim	e, date and place,	and due to the cau	use(s) and manner as s	tated
	To the Hospitel or Attending Physician: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	Medical Certification:	(Check only 2 Medical E	xaminer: On the basis of and manner stat	examination and/or inv	estigation, in my op	pinion, death occurr	ed at the time, dat	e and place, and due to	o the cause(s)
	To To To To To To To To To To To To To T	2	29b. Signature and title of certifier	mid		29c. License OCME			d. Date signed (Month, larch 15, 2	
			hig his.							
			30. Name and address of person w	no completed cause of de	ath (Item 23a) (Type,	Print) 111 Pe	nn Street	, Baltim	ore, Maryl	and 21201
	Sta		31. Date filed (Month, Day, Year)	32. Registrar	's Signature				,	21201
	Registr	ar	MAR 1 9 2004	Gazara	p pp	orks				

			For State Registrar	State of	Maryland	/ Depa	artmen	t of H	ealth a Death	and M	ental Hyg	liene 20	004	08858
	Physici /Medic		Decedent's Name (First, Middle, Last) Mary Lou Jenkins							2. Date of Dea Month March	th Day	Year 1	3. Time of Death 10:45 A ^M	
) 	Examin			e- Herit	age Cent		Dui If Under	ndal	If Under	24 Hrs.	8. Date of Birth	4c. County of Baltin	of Death	place (State or Foreign
	Director		213–36–0407 Usual Residence of Decedent 10a. State 10b. County	1□M 2XTF	66	Yrs.	Months	Days	Hours	Min.	(Month, Day December	9, 1937	MD	-
	the Maryla 28a-f shov	ector	MD. Baltimo	ore	,	undal		Code				0g. Citizen of W		1 ☐ Yes 2X No
"	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Importants: If item 27 is marked other than "natural", or items 23a or 28a-1 show any njury or other traumatic event, if a Mudical Enterin at Irunal & restlind an once.	Funeral Director	8205 Gray Haven F 11. Marital Status 1 Never Married 2 Married	12. Was Deced	dent Ever in U.S. ces? No		21: Was Deced If Yes, spec	222 ent of His rfy Cubar	spanic Orig n, Mexican	gin? (Spe i, Puerto F	cify Yes or No- Rican, etc.)	USA 14. Race Black	- Americ	ean Indian, etc.
Maryland 21215-0036	nin 72 hours a in "natural", o Medicel Exer	Completed by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's € (Specify only highest g Elementary/Secondary (0-12)	If Yes, Give Year or Da	les:	16a. Dece	dent's Usua kind of wor DO NOT us	l Occupa	urina most	t of workin	g	Specify:		
and 212	d be filed with sental Hygiene ked other that cevent, itself	To Be Com	12 years 17. Father's Name (First, Middle, Las Charles Henry	1 year	401 377	Fo	od Se:		18. Mothe			Western Maiden Sumame onet		ctric
	and 2 should be lealth and Mental m 27 la marked of her traumatic eve	1	19a. Informant's Name/Relationship William M. Jenkir		and 8	3205	Gray 1	Have	nd Numbe n Roa	r or Rural	Route Number	, City or Town, S undalk, N		
Baltimore,	permit. Pages 1 are Department of Heal Important: If item any njury or othe once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 i 4 ☐ Donation 5 ☐ Other (Spec	ify)		iew C	sition (Name and	ory		larch 200	19 , 4	20c. Location - 0	re C	ity,MD.
Ba	permit. Departi Imports any nji		23a. Part. Enter the disease, or cor shock, or heart failure. List only	les	used the death.	Do not ent	onnel 110 So er the mode	ly Front State of dying	unera rs Pc	íl Hoi oint cardiac or	me Of D Road, D respiratory arre	undalk,I undalk,I	AD.	21222 Approximate Interval Between
8760,	Physician /Medical Examiner physician and physician with physician physician and physician physi	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to to	r as a consequent RONI (as a consequent RONI)	nce of):	ON TI AL	A	HC DI		SM	ER		1000 and 100 party S 64 PARS 504 EARS 24 EARS
.O. Box 6	death certific e attending p d for use as	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		th 2 ☐ Fetal de nt at time of deat	eath 3□	Ectopic pre					23d. Date Mont		ry Day Year
ords, P	The law requires that the tee has been signed by thoage 2 should be detache	ρ	Part II. Other significant conditions	contributing to dea	ath but not resulting	ng in the u	nderlying ca	iuse give	n in Part I.				oute to th	ecause of death?
al Reco		e Completed	25. Was case referred to fiedical							_		pr ned? de	ior to con ath?	osy findings available npletion of cause of 2 No
Division of Vital Record	Phys this al dii	To B	examiner? 1 Yes 2 No 27. Manner Death 1 Actural 5 Pending 2 Accident investigation	28a. Date of (Month)		VOutpatien Bb. Time of Injury		A Other Bc. Injury Work	at	rsing Hom		a nce 6 ⊡Other winjury occurre		·)
Divis	Hospital or Attending I 24 hours after death. Funeral Director: After tely filled in by the funer	al Certification;	3 Suiside 6 Could not be							d place, ar	City or Town	use(s) and man	ner as sta	ated.
•	To the Hospital or within 24 hours afte To the Funeral Dir. completely filled in I	Medical	(Check only 2 ☐ Medical Exe	miner: On the bas and manne	is of examination	n and/or inv	estigation,	in my opi	nion, deati	60	d at the time, da	ete and place, and place, and place and place signed	id due to	the cause(s)
	2		30 Name and pourses of person who	Somple De dau Co	of deal (Item 20	(1) (1) (pg	Print) St	119	-A	RI	TCHIT	= HG	HV	1A4,
	Sta Registr		31. Date filed (Monapy, Year)	2004 32.6	gistrar's Signatur		ومحمد	1-1	t****	1	14/17	- WIN	04	125

State of Maryland / Department of Health and Mental Hygienes Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** Dorothy L. Kreiner 16,2004 6:15 P M March /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 17413 Pretty Boy Dam Road Parkton Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2X F Yrs. 218-28-9721 72 Director 6, 1932 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or Items 23s or 28a-f shov svent, the Moulcal Examinat must be notified at 1 ☐ Yes 2 🔀 No Director Md. Baltimore Parkton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with I ment of Health and Mental Hygiene.
The I liem 27 is marked other than "natural", or items 23s or ; and yor other traumatic svent, I'm Maulcal Examination ury or other traumatic svent, I'm Maulcal Examination. 17413 Pretty Boy Dam Road 21120 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No Baltimore, Maryland 21215-0036 Yes, Give 1 ☐ Yes 2 ☑ No Specify: Specify: 3 N Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Executive Secretary Insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Allen H. Harris, Sr. Loretta Rochford 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14204 Beddingfield Way Centreville, Virginia 20121 ce of Disposition (Name of Date 200. Location - City of Town, State Richard Kreiner/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1 Department of H Important: If ite any injury or ot 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Mem. Grd. 3/22/04 Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Lice see Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part1. Enter the disease, or plication shock, or heart failure. List by one q Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Errier underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): ner The law requires that the death certificate be executed burial-transit Completed by Physician/Medical Exami and Due to (or as a consequence of). P.O. Box 68760. as the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 10 Month Year Day 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? of Vital Records. should be 1 Tes 2 3 NO 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death Check onli one Hospital: Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) Certification: To 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describ tow injury occurred Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: 2 Accident 3 T Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide completely filled Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Modical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. o the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 31. Date filed (Month, Day, Year) State MAR 1 9 2004 Registrar

			1 - For State Registrar	ate of Marylan	id / Depa	artment o	of Heal	th and M	ental Hyg	giene 2 (004	08860			
	Physici /Medio Examir	al	1. Decedent's Name (First, Middle, Last) MARTORIE 4a. Facility Name (If not institution, give street Howard County Gener	and number)	KR6	4b. City, To	wn, or Loca 1umbia	tion of Death	2. Date of Dea Month 0 3	Day 4c. Coun	Year O	3. Time of Death			
	Funeral Director		Social Security Number 6. Sex	ecurity Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date (Months $\frac{1}{2}$ Months $\frac{1}{2}$ Months $\frac{1}{2}$ Months $\frac{1}{2}$ Min. $\frac{1}{2}$ July 3.							pate of Birth Month, Dey, Yeer) 1 y 30, 1938 MD				
	within 72 hours after death with the Maryland ene. then "natural", or items 23e or 28e-f show ta Madical Exemirer must be notified at	Director	MD Howard	10c. Cit	y, Town or Lo	sup						od. Inside City Limits 1 ☐ Yes 2√ No			
	leath with t ns 23a or 2 must be n	Funeral Dir	10e. Street and Number 8255 Savage-Guilford	as Decedent Ever in U.	.S. 13.1		20794	c Origin? (Spe		10g. Citizen of USA	What Coun				
9000	nours after dural, or Itan	þ	1 Never Married 2 Married 1	med Forces? □ Yes 2 □ VNo Yes, Give A ear or Dates:		f Yes, specify 1 ☐ Yes 2 ☐		xican, Puèrto F ecity:	cify Yes or No- Rican, etc.)	BI	ack, White, 6	etc.			
21215-0036	should be filed within 72 hours after death with the Marylan of Mental Hygiene. marked other then "natural", or Itams 23s or 28s-1 show imate event, the Modical Exeminer must be notified a	Completed	15. Decedent's Education (Specify only highest grade com Elementary/Secondary (0-12)	oleted) ollege (1-4or 5+)	(Give	dent's Usual C kind of work of DO NOT use r upervis	done during retired)	most of workir	9	Food		·			
Maryland	should be filed and Mental Hygie marked other umatic event, It	To Be (17. Father's Name (First, Middle, Last) John R. Streaker,					Elsie							
	1 and 2 : Health ar em 27 Is other trau		19a. Informant's Name/Relationship (Type, Pl Mr. James M. Krebs (20a. Method of Disposition	Son)	8038	Round	Moon		Route Number Jessu ate						
Baltimore,	permit. Pages Department of i Important: If It eny injury or o once.		1 🕅 Burial 2 □ Cremation 3 □ Remov '4 □ Donation 5 □ Other (Specify) 21. Signature/of Funeral Service License/e	al from State Mt.	· View	Cemete	rpiace) ery	3/20,	/2004	Marrio	ottsvi	11e, MD			
	P. T. D.		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cau	s that caused the death se on each line.	10)	VERATI	<u>.1e, 11</u>	D 21/04	& CHAP 4 (410)- respiratory arr	-/95-14	+00	Approximate Interval Between			
* -	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	disease or condition								Onset and Death			
760,	ate be executed hysicien and the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):							2					
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Records, P.	w requires that been signed b should be deta	by	Part II. Other significant conditions contribution	ng to death but not resu	ulting in the ur	nderlying caus	e given in P	art I.	II.	bacco use cor es 2□No		cause of death?			
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	To the Hospitel within 24 hours a To the Funeral Completely filled	Medical		To the best of my known the basis of examinated manner stated.	wledge, death tion and/or inv	estigation, in	my opinion,	death occurre	d at the time, da	ate and place,	and due to	he cause(s)			
	To To con	~	29b. Signature and title of ca particles	0		\mathcal{L}		303		9d. Date signe	7/01	4			
	Ó		30. Name and address of person who complete RODOLFO FERM	M. F.MM	0 4	STR	EDEV	zick	2D St	162	CATO	~s ville			
100 m	Sta Registr	1770	31. Date filed (Month, Day, Year) MAR 1 9 2004	32. Registrar's Signal	ture	المكان									

State of Maryland / Department of Health and Mental Hygiene For State Registrar 04 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** MRCH 2004 16 Joan Patricia Kopasek /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner CARE N/A BALTIMORE ST. AGNES Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 5. Social Security Numbe 219-38-1381 Min. Days Hours 1 ☐ M 2 🛣 F 63 July 25, 1940 Maryland Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State 10b. County Item 27 is marked other than "naturel", or Items 23a or 28a-f show other traumatic event, the Medical Execution mainteer collined at Baltimore 1 ☐ Yes 2 No Maryland Arbutus Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 5212 Larlin Rd. 21227 U. S. A. Funeral Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 △ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. I important: If Item 27 is marked other than "natural; or Item eny injury or other traumatic evant, the Medical Evol 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: White Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Clerk Video Store 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be William Slattery Mildred Barger ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore, MD. John Kopasek, husband 5212 Larlin Rd. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 03-20ate04 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Elkridge, Maryland Meadowridge Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funegal Service Licenses Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus, MD rollung 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final metastatic breast Concer unknown **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed use as the burial-transit attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) been signed by the a should be detached to 9 Unknown Ö 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Records, hypertension tiovillation 4 Unknown atrial 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 : autopsy performe 1 Yes 2 No Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director. Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Appatient 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Medical Certification; To o (his 28b. Time of Injury completely filled in by the funeral 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident Division 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death. To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of dertifier Į. P-15631 March 16, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

400 Caton Avenue Baltimore, Maryland 21229 31. Date filed (Month, Day, Year) egistrar's Signature State MAR 1 9 2004 Registrar

DHMH 17 Rev 1/2001

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	Funeral Director		5. Social Security Number 6. Sec 0210 - 410 - 1520	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		9. Birth	nplace (State or Foreign untry)				
	land		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ty. Town or Lo	cation			1	10d. Inside City Limits				
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Mar	and 2 sh salth and n 27 is m		19a. Informant's Name/Relationship	oe, Print)	19b. Mailin	g Address (Street	and Number or R	ural Route Number, C	ity or Town, State, Z	ip Code) 21131				
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Baltimore,	t. Pages rtment of I rtant: If th		*4 □ Donation 5 □ Other (Specify)	Dula	neyVall	ey Men G	ardens 3	20-04 Ti	monium	am,				
Ba	permit. Departimport Import any inj		21. Signature of Funeral Service License	autotica	Dr.	2325 V	ORKRD TEOLATI	Timoniu	M, MD 210	193.				
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ion	Attending ir death. actor: After by the fune	atlon	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	28c. Injur Wor M 1 🗀	yat k? Yes 2 □ No	200. Describe now	njury occurred					
Division of	tal or Atte s after de al Diracto ad in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, stre	et, factory, office		28f. Location (Stree City or Town, S	t and Number or Rur tate)	al Route Number,				
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	Lake		30. Name and address of person who cor	mpleted cause of death (Item	1 23a) (Type, I		7254	2	106/04					
3000	10		BOON P. IM M.D	7671 051 F	R DRI	VE TOWS	ON MAR	YLAND 218	2714					
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			1 - For Amend Item 23a,Pt	State of Maryland I per Dr.,G829,0	/Depa	rtment o	of Health of Death	and Mo	ental Hy	giene 2	004	08863
	العالية		Decedent's Name (First, Middle, Last)						2. Date of Dea	ath		3. Time of Death
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	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las		If Under 1 Y	ear If Unde	r 24 Hrs. Min.	8. Date of Birt (Month, Day	h /, Year)		lace (State or Foreign
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	and *		Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Lo	cation					1	Od. Inside City Limits
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		ų.	30. Name and address of person who com K. Ambalavavar	pleted cause of death (Item 23		ce Lan	ne Li	-1 (a tone	illo. v	ND 31	3 ^{rel} 2004
33	Sta Registr		31. Date filed (Month, Day, Year) MAR 2-0 2004	32. Registrar's Signature		,						

D			1 - For Amend Item 1 per	State of Maryland / Depa ME, G829, 03/19/04dhb Cei	artment of Health and Natificate of Death	Mental Hygien	2004	08864
	Physici		1. Decedent's Name (First, Middle, Las	F. Mondsho	:1R	2. Date of Death Month March 15,	^{ay} 2004 ^{Year}	3. Time of Death 1500P. M
	/Medic Examin		4a. Facility Name (If not institution, give 601 Cornell Stree	street and number)	4b. City, Town, or Location of Death Aberdeen	40	County of Deeth Harford	
0	Funeral Director		10000.70°011X	7. Age (In yrs. last birthday) M 2 F 53 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year, 3-//-5	9. Birthp Court	lece (State or Foreign ltry)
	Aaryland f show	or	Usuel Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo			1	0d. Inside City Limits
	with the A Se or 28a-(i Director	100. Street and Number	as Anthris	10f. Zip Code	10g. Ci	itizen of What Cour	itry?
936	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Menial Hygiene. If Item 27 is marked other then "natural", or Itema 23a or 28a-f show or other traumatic event, the Medical Examinar must be mailted at	by Funerai	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 🕅 No	Was Decedent of Hispanic Origin? (St If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ₩ No Specify:	pecify Yes or No- p Rican, etc.)	14. Race - Americ Black, White,	
21215-0036	within 72 houlene. Then enature	Completed	15. Decedent's Ed (Specify only highest gra	de completed) (Give	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	king 16b. F	(ind of Business/Ind	Justry
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.O. Box 68	eath certific attending p for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		Ectopic pregnancy Other (specify)		23d. Date of delive Month	ry Day Year
۵.	w requires that the d been signed by the should be detached	þ		ontributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacco 1 ☐ Yes 2	use contribute to th	
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of Vita	Physician: this certific ral director,	To Be	IN THE ZUNO	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien	ot 3 DOA Other: 4 Nursing He	th (Check only one)	Other (Specify	(scene)
Division o	Attending or death. ector: After by the fune	Certification:	27. Menner of Death 1 Natural 2 Accident investigation 3 Suicide 6 Could not be determined	28a. Date of Injury (Month, Day Year) 28b. Place of Injury - At home, farm, str building, etc. (Specify)	Work? M 1 □ Yes 2 □ No	28d. Describe how inju 28f. Location (Street as City or Town, State	nd Number or Rura	l Route Number,
	Hospita Hours Funeral Fely filled	edical Ce		ysicien: To the best of my knowledge, death iner: On the basis of examination and/or in- and manner stated.				
	To the within 2 To the complex	Mec	29b. Signature and title of certifier	Greenberg M.D.	29c. License number O.C.M.E.		ate signed (Month, I	
C	2			completed cause of death (I/m 23a) (Type,	Print) 111 Penn Stre	et, Baltim	ore, Mary	land 21201
	Sta	ite	31. Date filed hear Day, Gar 200	32 Registrar's Signature	dis.			

State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2004 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 15, 200¹/₄ MARCH **Physician** MCGOWAN 4:50 P. M THERESA /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Fecility Name (If not institution, give street and number) Examiner MAMAISON ASSISTED LIVING PERRY HALL BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign
Country) **Funeral** Days Hours 1 ☐ M 2 🛛 F 213-12-3783 7/28/1901 MARYLAND Director 102 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "natural", or items 23s and entitle my injury or other traumether. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ☑ No Director PARKVILLE BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21234 USA 1815 WENDOVER ROAD Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: WHITE 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) MCCORMICK & CO. LINE OPERATOR 8TH GRADE 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be AGNES UNAVAILABLE GABRIEL SCHATZ 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 1759 WESTON AVENUE BALTIMORE, MD 21234 DAUGHTER BETTY HUBBS 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 3/19/2004 HILLENDALE, MD MORELAND MEM. PARK 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD Approximate Interval Between Onset and Death 2 art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) NEUMONIA WEEKS **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transit ed by the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy Day in the past 12 months? Month Year 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by sign 1 be MELLITUS 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 autopsy performed? certificate 1 Yes 2 No.No. filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) ASSISTED Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1 ☐ Yes 2 ♠No Certification: To this LIVING 28a. Date of Injury (Month, Day Yeer) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After or Attending 1 Natural 5 Pending investigation 1 Tes 2 No after death. death. 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CILBRID ROAD NOTTINGHA 21236 ALLAGE MD 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Mikal Mumin State of Maryland / Department of Health and Mental Hygiene 25tate of Maryland / Department of Health and Mental Hygiene 25tate of Per ME, 0829, 3210 Jegs Reg. No. 2 Reg. No. 2 04 - 1859004 AKG 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Mikal Mumin March 14, 2004 9:25 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner John Hopkins Hospital Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1**X** M 2□ F Director 02/09/1956 Maryland 220-64-8451 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits in than "natural", or Items 23a or 28e-f show the Medical Examiner roust be notified at 1X Yes 2 No Directo Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2628 E. Hoffman Street 21213 Completed by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. t and 2 should be filed within 72 hours after of Health and Mental Hygiene. The stream 27 is marked other than "natural", or ten other traumatic event, the Modical Executor. 1 ☐ Yes 2 ☐XNo 1 Never Married 2 Married 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐XNo Specify: Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Barber Hair cutting 9 Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Julius Caesar Bernice Virginia Williams ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health item 27 i 2628 E. Hoffman St., Baltimore, Maryland 21213 Vinet Caesar / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State Pages ō ± 5 1 TBurial 2 Cremation 3 Removal from State permit. Page Department of Important: If any injury or * 4 ☐Donation 5 ☐ Other (Specify) Mt. Zion Cemetery 03/22/2004 Landsdowne, Maryland 22. Name and Address of FacilityThe Derrick C. Jones F/H,P.A. 21. Signature of Funeral Service Lice 4611 Park Hgts. Ave., Baltimore, Maryland 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cabo on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cocaine Intoxication Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. by Physician/Medicai as the l IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? detached for Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. ig a 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Dunknown Be Completed should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☑ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? Vital 1 Yes 2 No or Attending Physician: in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospilal: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2□No ၉ of 28a. Date of Injury (Month. Day Year) Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Alter Division 5 Pending investigation 1 Natural found 9:25p found 3/14/04 1 ☐ Yes 2 🗶 No unknown death. To the Hospital or Attand, within 24 hours after death To the Funeral Director: / completely filled in by the fi 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify)

found at residence 28f. Location (Street and Number or Rural Route Number determined 4 Homicide 2628 E. Hoffman St., Baltimore, MD Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

**Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) mil hi O.C.M.E. March 15, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

e 31. Date filed (Month, Day, Year) MAR 1 9 200

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111 Penn Street, Baltimore, Maryland 21201

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene 2.0.0.1.

		A	MEND ITEM #26 PER	PHY G8	29 3/19	0/04 Jh		rtificate			Mental my	Reg. No.	UUG	UBB	5/
	Physicia	n	1. Decedent's Name (First, Mid-		10 1	M a a i	1	~			2. Dete of De Month	eeth Day	Year	3. Time of De	
4 10	/Medica	al -	VIRGINIA 4a Fecility Neme (If not instituti	Pec on, give str		Meck	EL		T	b. City, Town, or	MARCH Location of Dear	1 2 h 4c. Cour	2004 nty of Death	9 A	W
	Examine	r	1701 RUFFS			Road				BEL	AIR		RFOR	D	
	Funeral Director		5. Social Security Number 219–28–9978	6. Sex		7. Age (In yr. 7.	s. <i>last birthday)</i> L Yrs.	If Under Months	1 Year Days	If Under 24 Hrs Hours Min		th ay, <i>Year)</i> r 7,19:	9. Birthr Cour 32 Ar	lace (Stete or Fo try) Kansas	oreign
	word		Usuel Residence of Decedent 10a. Stete 10b. Count	у		10c. 0	City, Town or Lo	cation					1	0d. Inside City L	
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	with the		10e. Street end Number 199 Highland	Circl	Θ			10f. Zip	Code 0513			10g. Citizen o	of What Cour	itry?	
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00	hours tural',	S S	3 XWidowed 4 ☐ Divorce		Year or Da	ates:						Specification 16b. Kind of	WIII		
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Maryland	d Ment d Ment marked martic	٥	Archie Til 19a. Informant's Name/Relation	lman		eck_	10h Mailie	A delegan	(Street	Lucille	urel Route Numb		Austir		
Ma	nd 2 s alth en 27 is r r traus		David R. Hopes					•	1		ill, Te			•	
ore,	jes 1 e of Hei f Item or othe		20e. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 √ Rei	moval from S	20b.	Place of Dispo cemetery, crer	sition (Nam natory or of	ne of ther plac	:0)	Date	20c. Locatio	n - City or To	wn, State	
Baltimore,	it. Peg rtment rtant: I njury c	-	4 □ Donation 5 □ Other (21. Signature Fune al Service	Specify)		Chu					3/17/04		Ridge,	Georgi	La
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68760,	ete be hysicie the bur	lcal	Cause (Disease or injury that initieted events resulting in death) Last	C		Due to	or as a conseq	uence of):							
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Division of Vital Records, P.O. Box	To the Hospital or Atending Physician: The law requires that the death certificate be executed within 24 hours efter death. To the Funeral Director: After this certificate hes been signed by the ettending physicien end completely filled in by the funeral director, page 2 should be deteched for use as the bunel-trensit	Medical Certification: To be completed by Physician/N									24a. Was	an autopsy med?	ava	ere autopsy findi allable prior to npletion of caus death?	-
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DIX	Ital or Attend Its efter death al Director: /	Ze Z	4 ☐ Homicide deten	mined	buildir	ng, etc. (Spec					City or To	wn, State)			,
	To the Hospital or within 24 hours effe To the Funeral Dir. completely filled in	edical	29a. Certifier (Check only one) 1 Certifyl 2 Medica	ng Physic Examine	lan: To the r: On the ba and menn	sis of examin	owledge, death ation and/or inv	occurred a estigation,	it the tim in my op	ne, date and place pinion, death occi	e, and due to the urred at the time,	cause(s) and a date and place	manner as st e, and due to	ated. the cause(s)	
	vithir To th	Σ	29b. Signeture end title of certifi	er [] ,	/					number		29d. Date sign	ned (Month, i	Day, Yeer)	
	XX	\	Bernard of	· Yilm	n M	DINE	m 02c) (T::::::		00 1	4206		March	12, 20	94	
	13		BERNARA J.	YUK	CIVA.	MD.D	m 23e) (Type, ME		HUL	A PIRD A	IVE BA	LTD MI	1 2/2	25	
П	State	18	31. Date filed (Month, Day, Year	₂ / 2004	2. Re	egistrer's Sign	ature	<i>d</i> .							

			Sta	ate of Maryland	/ Depai	tment of I	Health a	ind Mei	ntal Hygi	ene	
		•	For State Registrar	,	Cert	ificate of	Death		Re	g. No. 200L	08868
	at a st.	23	Decedent's Name (First, Middle, Last)						Date of Death Month		3. Time of Death
	Physicia /Medic		Kevin Patrick McMaho		- 1				arch 15	4c. County of Dea	9:36 P M
	Examin	er	4a. Facility Name (If not institution, give street			4b. City, Town,	or Location of	r Death			
		(A)	Greater Baltimore Med 5. Social Security Number 6. Sex	ical Center 7. Age (In yrs. Ia		Towson If Under 1 Year		24 Hrs. 8.	Date of Birth (Month, Day,	Baltimor	thplace (State or Foreign ountry)
	Funeral Director		147-28-8536 1 ¹ / _x ^M ²		Yrs.	Months Days	Hours	Min.	ec. 5,	1936 Ne	w Jersey
	pc ,		Usual Residence of Decedent 10a, State 10b, County	10c City	Town or Loc	ation					10d. Inside City Limits
	shov	'n	Harford	100. 01.9,		Fallsto:	n				1 ☐ Yes 2 ☐kNo
	the M 28a-f	Director	Md. 10e. Street and Number			10f. Zip Code			10	g. Citizen of What C	
0	Swithin 72 hours after death with the Maryland siene. Then "naturel", or Items 23a or 28a-1 show the Madical Examination in the Madical Examination.	ai Di	2116 Givenswood Driv	e			21047			United S	tates
2	ems	Completed by Funeral	Ar	as Decedent Ever in U.S med Forces?	3. 13. W	as Decedent of Yes, specify Cub	Hispanic Orig pan, Mexican	gin? (Specif , Puerto Ric	y Yes or No- an, etc.)	14. Race - Am- Black, Whi	
36 6	s afte	J. F.	1 Never Married 2 Married 1 In 1 In 1 In 1 In 1 In 1 In 1 In 1 I	⊋Yes 2□No Yès, Give Kore earorDates: Core	an	☐Yes 2 🗷 No	Specify:			Specify:	white
	tural	edit	15. Decedent's Education	Cont	lict 16a. Decede	nt's Usual Occu	pation	a da dila a	1	6b. Kind of Business	/Industry
	hin 72 a. an "na	piet	(Specify only highest grade complete (Specify only highest grade complete (0-12)	pleted) bliege (1-4or 5+)		ind of work done O NOT use retire	a auring most ad)	or working		1 1.	
2 2	D 0 -	Con	12 years]	pipe	fitter	10 Motho	r'a Noma (f	Eight Middle M	plumbin Haiden Surname)	g
AMON ,	7 2 7 9	Be	17. Father's Name (First, Middle, Last) Patrick Joseph McMah	on					'Rourke		
Maryland	ges 1 and 2 should be fi t of Health and Mental H If Item 27 is marked of or other traumatic ever	ဥ	19a. Informant's Name/Relationship (Type, Pr		19b. Mailing	Address (Stree	t and Numbe	r or Rural R	Toute Number,	City or Town, State,	Zip Code)
	1 and 2 s Health ar tem 27 is		Diane J. McMahon/wif		2116	Givens	wood D	rive,	Fallst	on, Md. 2	1047
M Baltimore.	permit. Pages 1 and Department of Heali Important: If Item 2 any injury or other 000g.		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ Remov	20b. Pl	ace of Dispos metery, crem	ition (Name of atory or other pla	ace)	Date	9 2	0c. Location - City or	Town, State
im	Pages ment of l		* 4 ☐ Donation 5 ☐ Other (Specify)	St.	John's			3/19/	2004	Hydes, Md	•
Balt	permit. Departr Imports any inji		21. Signature of Funeral Service Licensee	0 -	S		k Fune	eral H		Bel Air,	
			23a. Part1. Enter the disease, or complication	ns that caused the death	. Do not ente	10 W. M	acPhai	1 Roa	d, Bel espiratory arre	Air, Md.	21014 Approximate Interval Between
	Pnysician		shock, or heart failure. List only one cau Immediate Cause (Final	ise on each line.	(5)						Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a consequ							July
	Examiner		Sequentially list conditions, b. —								
	pe list	Examiner	cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	ience or):						
_	be executed sician and burial-transit	Exan	that initiated events C.	Due to (or as a consequ	ence of):						1
760	ysicial	cal	d								
89	death certificate b attending physic	Physician/Medi	IF FEMALE:								
Box	ath ce attend for us	ian/	23b. Was decedent pregnant in the past 12 months?	yes, outcome of pregnar □Live birth 2 □ Fetal □Pregnant at time of de	death 3	Ectopic pregnan Other (specify)	су			23d. Date of de Month	Day Year
0	that the de ed by the detached	ysic		Unknown	,u	outer (apoeny)					
	The law requires that the death certificate ate has been signed by the attending phys agge 2 should be detached for use as the	by Pt	Part II. Other significant conditions contribut	ting to death but not resu	ilting in the un	derlying cause g	iven in Part I.				to the cause of death?
ļ ģi	w requires that she signed the should be det	ted	COPD						12 Ye	s 2 □ No 3 □ F	Probably 4 Unknown
	law renas be	Completed	hung Cancer						24a. Was an autopsy perform	/ prior to	utopsy findings available completion of cause of
	: The		3						1□ Yes 2	□ No 1 □ Ye	s 2 No
	sicien: The law s certificate has b lirector, page 2 sl	o Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospit	al: Inpatient 2	ER/Outpatien	3 00 00 C	thor		Check only one	nce 6 □Other (Sp.	ecity)
7	Physer this eral di	⊢	27. Manner of Death 28	a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. lnj				w injury occurred	ocity)
ا ا	ath. Te fun	atio	Natural 5 Pending investigation	(Month, Day You)			☐Yes 2☐	No			
Mission of Vital Becords	or Atte	Certification:	3 Suicide 6 Could not be determined 28	le. Place of Injury - At ho building, etc. (Specify		et, factory, office	8	28	f. Location (Str City or Town	reet and Number or F , State)	Rural Route Number.
	To the Hospitel or Attending Physicien: The I within 24 hours after death. To the Funerel Diractor: After this certificate ha completely filled in by the funeral director, page		29a. Certifier 1/2 Certifying Physician	n: To the best of my know	wiedoe death	occurred at the	time, date an	nd place, and	d due to the ca	use(s) and manner a	as stated.
	e Hos 24 h e Fun letely	Medical	(Check only 2 Medical Examiner: (On the basis of examinat and manner stated.	tion and/or inv	estigation, in my	opinion, dea	th occurred	at the time, da	ite and place, and du	e to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier				nse number	,	29	d. Date signed (Mor	nth, Day, Year)
			> M Chad			1020	0907			3/16/04	
ĝ	M		30. Name and address of person who comple	1 - 6	23a) (Type,	- Choc-la	0	, R	16	n M 1	21301
Ĺ		ate	31. Date filed (Month, Day, Year)	3. Registrar's Signa	ture	· Charle	7 0x /	100	Mono	wa , ma	21204
	Regist		MAR 1 9 2004	Bernes D	NA SEC	W.					7

			For State Registrar	State	of Maryland /		of Health and Moof Death	Mental Hygie		08869
	Physicia /Medic		Decedent's Name (First, M LARRY	iddle, Last)	S	MAG	ER	2. Date of Death Month	Day Year	3. Time of Death
-	Examin		4a. Facility Name (If not instit		Beltimore	7	on, or Location of Death	,	4c. County of Death	
	Funeral Director		5. Social Security Number 218-46-3443 Usual Residence of Deceden	6. Sex 1 M 2 F	7. Age (In yrs. last bi	rthday) If Under 1 Y		8. Date of Birth (Month, Day, Y SEPT 2,	(ear) 9. Birth Coul 1947 M	place (State or Foreign htry) ARYLAND
	Maryland I-f show fled at	tor	10a. State 10b. Cor		10c. City, Tov	vn or Location BALTIMORE				10d. Inside City Limits
	h with the 23a or 28s	al Director	10e. Street and Number 1821 RAMBLIN	NG RIDGE LA	NE #202	10f. Zip Co 2	1209	10g	D. Citizen of What Coul USA	ntry?
036	n 72 hours after death with the Maryland "natural", or Items 23a or 28a-f show "lical Examiner must be mailfied at	by Funeral	11. Marital Status 1 □ Never Married 2 3 □ Widowed 4 □ Divo	Armed 1 ☐ Yes	ecedent Ever in U.S. Forces? s 2 (A) No Give Dates:	13. Was Decedent If Yes, specify	of Hispanic Origin? (Sp Cuban, Mexican, Puerto No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify:	
9500-61212	within 72 ane. Ihan "nai	Completed	15. Dece (Specify only hi Elementary/Secondary (0- 12	edent's Education ighest grade completed		Decedent's Usual C (Give kind of work of life. DO NOT use r	one during most of work etired)	ring 16	Sb. Kind of Business/In	
Maryland 2		To Be Co	17. Father's Name (First, Mid RICHARD	ldle, Last)		AGER	HEL		RUBIN	
	s 1 and 2 should if Health and Mer Item 27 Is marke other traumatic		MYRA MAGER 20a. Method of Disposition		1		NG RIDGE LA	ANE, #202		MD 21209
Baltimore,	Pages 1 nent of H int: If Ite		1 □ Burial 2 □ Cremat 1 □ Donation 5 □ Other		m State cemete	ary, crematory or othe	r place)		REISTERSTO!	
Balt	permit. Pages Department of Important: If I eny injury or one		21. Signature of Funeral Sen	vice Licensee		22. Name and A	ddress of Facility SC		ON & BROS.	, INC. 21208
10 10	Physician		23a. Part1 En r the diseas show, or heart failured Immediate Cause (Final disease or condition	_		not enter the mode o		or respiratory arres	t,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due t	te Inter to (or as a consequence	of):	1 1 1 1 T	21 - Lan	TUN)	
	be sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due !	to (or as a consequence	of):	1000 / 12) War of F		
,09/	ate be executed hysician and the burial-transit	icai Examiner	that inflated events resulting in death) Last	c	to (or as a consequence	of):				
O. Box 68	death certific e attending p od for use as t	Physician/Medi	IF FEMALE: 23b. Was decedent pregnan in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live	outcome of pregnancy e birth 2 Fetal death egnant at time of death known	h 3 □Ectopic pregr 5 □ Other (specia			23d. Date of delive	ery Day Year
ds, P.	uires that the dei n signed by the a lid be detached f	by	Part II. Other significant con	uditions contributing to	death but not resulting	in the underlying caus	e given in Part I.		cco use contribute to t	./
Records,	Physician: The law requires that the this certificate has been signed by the tall director, page 2 should be delach	Completed	Coronary 1	Jetrny Di	34734			24a. Was an autopsy performe	prior to co	psy findings available mpletion of cause of 2 No
Division of Vital	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	To Be	25. Was case referred to me examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pe 2 Accident inv	Hospital: 1 [Other	th (Check only one) ome 5 Residence 28d. Describe how	ce 6 Other (Specif	y)
Divisi	al or Atter s after dea il Director sd in by the	Certification:	3 ☐ Suicide 6 ☐ Co	ould not be stermined 28e. Pla	ace of Injury - At home, filding, etc. (Specify)	arm, street, factory, of	fice	28f. Location (Stre City or Town,	et and Number or Rura State)	al Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medical	29a. Certifier 1 Cert (Check only one) 2 Med	lical Examiner: On the	the best of my knowledge basis of examination a anner stated.	e, death occurred at t nd/or investigation, in	he time, date and place, my opinion, death occur	and due to the cau red at the time, date	se(s) and manner as s e and place, and due to	tated. the cause(s)
	To the within To the comple	Me	29b. Signature and title of ce		440		cense number		d. Date signed (Month,	
•	b		30. Name and address of per	rson who completed or	ause of death (Item 23a)	(Type, Print)	0056333 mi Hungit	7	narch 15	2004
)		Chandres 31. Date filed (Month Day, Y	h Shil-	A M, D. Registrate Signature	5,1	Hygul in	IN A B	alkimae	
	Sta Registi		MAR 1 9 2004		* 1					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2004 Sandra **Physician** J. Oakman March 12, 3:14pm M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hosp. Montgomery Takoma Park 8. Date of Birth (Month, Day, Year) 08/15/1945 5. Social Security Number 024–34–3728 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country)
 MA 6. Sex **Funeral** 58 Months 1 ☐ M 2 🖾 🛠 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow er than "natural", or Itams 23a or 28a-f ahov The Madical Examiner must be notified at MD Montgomery Silver Spring 1 Yes XX No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1400 East West Highway #1418 20910 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XX0 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 72 hours after Never Married 2 Marned Baltimore, Maryland 21215-0036 white Yes. Give 1 ☐ Yes 2 No Specify: à 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) 'Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Law School Assistant Dean Adm. 12 0 s 1 and 2 should be filed if Health and Mental Hygi-item 27 Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be James W. Oakman Gena T. Venti ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If itam 27 Ian any injury or other traun James William Oakman/Brother 26 Crane Avenue, Maynard MA 01754 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State matory or other place) 1 Burial 2 Cremation 3 Removal from State Sleepy Hollow Cem. 119/04 Concord, MA 4 □ Donation 5 □ Other (Specify) 21. Signature of uneral Service Licensee Victor P. Doda, Jr. 22. Name and Address of Facility Charles L. Stevens Funeral Home, Inc 1501 East Fort Avenue, BAltimore MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Pneumococcal Immediate Cause (Final **Physician** disease or condition resulting in death) Weeks /Medical Due to (or as a consequence of): 3 wreks Examiner Cerebro vas cula Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner certificate be executed attending physicien and I for use as the burial-transit and Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) P.0. detached the 9 Unknown 9 Unknown δ signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 2 99 2 XNo 3 ☐ Probably 4 ☐ Unknown should Completed peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe (es 2) 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 XInpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Division Hospital or Attending 1 Natural 5 Pending investigation Injury death. 1 Tes 2 No 2 Accident within 24 hours after deati To the Funeral Director: in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide completely filled 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. To the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D37960 March 12, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAPLE AVE. TAKEMA PARK, MJ. 20912 7901 ms. W. 32. Registrar's Signature State MAR 1 9 2004 Registrar

		For State Registrar	ricasi	State of I		d / Depa		of He	ealth a				201	 04 ne	871
/Me	siciar edica mine	1. Decedent's Nam CHRI 4a. Facility Name (I	STINE not institution, g	ast) ive street and numb escent Cer	er)	RIEN		fown, or t	Location o	of Death	2. Date of Dea Month MARCH	Day 1 O 4c.	Ye, 2004 County of I	3. Time 6:00	
Funer Direct		5. Social Security N 214-50-9	9949	. Sex 7. 1 ☐ M 25 F	Age (In yrs. I	last birthday) Yrs.	If Under Months		If Under a Hours	Min.	8. Date of Birt (Month, Da May 19			Birthplace (State Country) Austria	or Foreign
ife, INTAINATE INTO INTO INTO INTO INTO INTO INTO INTO	od hy Europeal Disactor	3 ₩ Widowed	Anne Anne Anne Avenu	e 12. Was Decede Armed Force 1 1 Yes 2 If Yes, Give Year or Date	Ont Ever in U.	l 16a Dece	Was Decedif Yes, special United Street	ent of His fy Cubar	Specify:		cify Yes or No Rican, etc.)		Black, \ Specify:	t Country?	City Limits
IIBING ZIZIO- UId be filed within 72 Aental Hygiene. rkad other than "na tic event, tre Medic	Latelana O o O o T	17. Fathers Name	ndary (0-12) (First, Middle, La	grade completed) College (1-4	or 5+)	(Give life.	kind of word DO NOT use memak	k done di e retired) e r	uring most		(First, Middle,	Ow	n Hom		
Page Page Pant o		19a. Informant's N He1ga C 20a. Method of Dis 1 □ Burial 2 ' 4 □ Donation	Lark (Date of Desirtion 3	ughter) □Removal from Sta	ale [1414 lace of Dispo emetery, crer tro Cr	Oden esition (Name of the other of the other of the other of the other of the other	ton e of her place ry	Road	ode 0 8/18/	enton, late	MD 2 20c. Lo Bal	1113	y or Town, State	
PERILITIES DESIRER PARTIE PART	an al er	Immediate Cause disease or condition resulting in death)	ne disease, or oc rt failure. List on (Final	omplications that cau ity one cause privace a	sed the death h line. VL r as a consequence of the consequence of th	iculiuence of):	12 Ri	dge1	y Ave	cardiac o		olis	, MD	Approxima Interval Be Onset and	atween
BOX 68 / 60, eath certificate be execute attending physician and for use as the burial-transit			Last	d		uence of):			rlim	ia			3d. Date of	3 n	n
cords, F.O. bo wrequires that the death been signed by the atten should be detached for u	Denie in in in in in in in in in in in in in	in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other signi	months?			eath 5	Ectopic pre Other (spe	ecify)	n in Part I.		23e. Did to	obacco u	Month se contribu	Day te to the cause of	Year death?
The la			#.	y per Ko	alem	nia					24a. Was	rmed?	24b. Wer	e autopsy findings to completion of h?	s available
_ × × ± ₽	of of moisternisis	examiner?	M o	tion	Injury Day Year)	ER/Outpatier 28b. Time o Injury	f 28	Bc. Injury Work 1 🗆 Y	r: 4 Han	Ising Hor	(Check only one 5 Residence 1986). Describe h	dence 6 now injury	occurred /		
UNISION OF To the Hospital or Attending Ph within 24 hours after death. To the Funaral Director: After th completely filled in by the funeral			determine	Physician: To the be	, etc. (Specify	y) wledge, deat	h occurred a	at the time	e, date and	d place, a	City or Tow	vn, State) cause(s)	and manne	or Rural Route Nut	
To the H within 24 To the Fi		one) 29b. Signature and		aminer: On the basi	r stated.	non anworth	29c.	License	number			29d. Date	e signed (N	fonth, Day, Year)	
4		30. Name and add	ress of person when S.	no impleted cause	of death (Item	Α .	Print)	ne7	Cen	se H	ng Gra	m	brill	5,200 s hng 21	054
	State istra		1-9 21	32. Reg	istrar's Sinna	130	E)				,				

			For State	State of Maryla		artment of H		Mental Hygi	ene g. No. 200	L 08872
			Registrar 1. Decedent's Name (First, Middle, La	e e l	Cel	lineale or L	Jeani	2. Date of Death		3. Time of Death
	Physicia	an		51)	OAKE	O D D		Month	Day Yea 13 2004	r
	/Medic		MILDRED 4a. Fecility Name (If not institution, give	o street and number)	OAKF		Location of Death	J	4c. County of De	
	Examin	er				Severna			Anne A	
	.		GENESIS ELDE 5. Sociel Security Number 6. S		s. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9.6	Birthplace (State or Foreign Country)
	Funeral Director			1□ M ¾□XF 92	Yrs.	Months Days	Hours Min.	JAN 10		ennsylvania
щ.			Usuel Residence of Decedent						, - ,	
	show		10a. State 10b. County	10c. C	City, Town or Lo	cation				10d. Inside City Limits
:	8-1-8	ctor	MD ANNE A	RUNDEL S	EVERNA	PARK				1 □ Yes 2 No
	or 28	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What	Country?
	i witin 72 hours after death with the Maryland jiene rthan *natural*, or Items 23a or 28a-f show tre Medical Examinar must be rudified at		24 TRUCKHOUS				146		USA	
	tems Fermi	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Hace - Al Black, W	merican Indian, hite, etc.
S.	hours after tural', or Ite al Examine	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		1 □ Yes 2 No	Specify:		Specify:	WHITE
9500-6121	Tural Ex	d be	15. Decedent's E		16a Decer	dent's Usual Occupa	ation	1	6b. Kind of Busine	ss/industry
င်	within 72 ene. than nai	Set	(Specify only highest gra	ade completed)	(Give	kind of work done of DO NOT use retired	during most of world)	king .		,
	filed withit Hygiene. other than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	Homem	aker			Own Hom	ie
0	E P E	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Nam	e (First, Middle, M	laiden Sumame)	
<u> </u>	od 2 should be th and Mental 27 is marked o 1 raumatic ave	To B	Shelby Kershner				Marth	a Hunter		
Mary	should to		19a. Informant's Name/Relationship	Type, Print)	19b. Mailir	ng Address (Street a	and Number or Ru	ral Route Number,	City or Town, State	a, Zip Code)
Ž	1 and 2 Health a tem 27 is		Roy C. Oakford ((Son)	1345	2 Field S	Stone Way	, Gaines	ville, VA	20155
อ์	of Healt item 2 other	1. 6.	20a. Method of Disposition		. Place of Dispo	sition (Name of matory or other place	θ)	Date 2	oc. Location - City	or Town, Stete
Ē	Pages nent of int: If it iry or o	3	VOXBurial 2 ☐ Cremation 3 ☐ *4 ☐ Donation 5 ☐ Other (Speci	fy) P	hiladel	phia Mem.	Pk 3/17	/2004	Malvern,	PA
	permit. Pages Department of the Important: If ite any injury or of otice.		21. Signature of Funeral Service Lice	No.	22 H	2. Name and Addres	ss of Facility Funera	1 Home	ANNAPOL P.A 12R	IS,MD 21401 IDGELY AVE
	20240	8	23a. Pert1. Enter the disease, or com	polications that caused the de						Approximate
			shock, or heart failure. List only Immediate Cause (Final	one cause on each line.						Interval Between Onset and Death
)	Physician /Medical		disease or condition resulting in death)	a. Due to (or as a cons	menu	l .	*			/week
	Examiner		1	Due to (or as a const	equence on.	Leart	Fax	Prine		/ week
4	2 A	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a conse			/ 00 =			
MA	d d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initieted events	^						
Ó	death certificate be executed e attending physician and id for use as the burial-transit	Exa	resulting in death) Last	Due to (or as a conse	equence of):					1
8760	ate b hysic the bi	dical	•	d				30		
9	entific ling p	Mec	IF FEMALE:	00. 16		7				
Box	leath certifica attending ph I for use as th	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of preg	etal death 3	Ectopic pregnancy			23d. Date of Month	Day Year
0	the a	Completed by Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at time of 9☐ Unknown	rdeath 5L	Other (specify)				
٥.	The law requires that the de te has been signed by the a vage 2 should be detached f	Ph	Part II. Other significant conditions	contributing to death but not r	esulting in the u	inderlying cause give	en in Part I.	23e. Did tob	acco use contribute	to the cause of death?
Division of Vital Records,	sign d be	d b	Cormary	Artery 1) Mear	P		1 ☐ Ye	s 212 No 3□	Probably 4 Dunknown
င္ပဲ	w require been sig should b	ete						24a. Was an	24b. Were	autopsy findings available
Re	has ge 2	dm	Marenlar	Desa	Can to C	и.		autopsy	/ prior death	to completion of cause of
æ		e Co	25. Was case referred to medical	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			ac Place of Dec	1 ☐ Yes 2		es 2□ No
=	sicia certi irecto	00	examiner?	Hospital: 1 ☐ Inpatient 2	☐ ER/Outpatie	nt 3 DOA Oth			nce 6 □Other (S	necify)
ō	Phy ir this aral d	. To	27. Manner of Death	28a. Date of Injury (Month, Day Yeer)				28d. Describe ho		posity
o	th.: Afte	atlo	1 Natural 5 Pending 2 Accident investigation) Inju ry		Yes 2 □No			
/8	Attending Physician: r death. sctor: After this certifica by the funeral director,	ifica	3 Suicide 6 Could not 9 4 Homicide determined		t home, farm, st	reet, factory, office		28f. Location (Str City or Town		Rural Route Number,
	tel or s afte el Dir	Certification:	Tiomicide	building, etc. (Spe	cny)			Only of Your	, Oluloy	
	To the Hospitel or Attending Phys within 24 hours after death. To the Funerel Director: After this completely filled in by the funeral di	edical	29a. Certifier 1 Certifying P (Check only 2 Medical Exa	hysician: To the best of my k iminer: On the basis of exami and manner stated.	knowledge, deat ination and/or in	h occurred at the tin evestigation, in my o	ne, date and place pinion, death occu	, and due to the ca rred at the time, da	use(s) and manner ite and place, and o	as stated. due to the cause(s)
	ompl	₩ We	29b. Signature and title of certifier			29c. Licens			d. Date signed (Me	
)	F > F 0		Wheneen	2 Attendin	g Doet	D.	21684		3-15	-2004
	8	1	30. Name and address of person who	completed cause of death (III	m 23a) (Type,	Print) HUZ LOV	JY, PAS	ADRNA	MD 21	122
The to	Sta Regist	ate rar	31. Date filed (Ment) Pau Year)	32 Registrar's Sig	gnature	ads a				

			For State	State of Maryland		Health and M	ental Hygier	ne2001	08873
	Physici /Medic	al	1. Decedent's Name (First, Middle, La 1. Decedent's Name (First, Middle, La 4a. Facility Name (If not institution, giv	PAHillo			March	Day Year	3. Time of Death
	Examir Funeral Director	er	Good Samari + c 5. Social Security Number 6. S	an	1		8. Date of Birth (Month, Day, Ye. 02/23/193	4c. County of Death 9. Birthp Cour 8 Mary	place (State or Foreign
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I're Medical Exantrar must be redified at any once.	Funerai Director	Usual Residence of Decedent 10a. State 10b. County Maryland 10e. Street and Number 1635 Waverly Way	10c. City, To	own or Location 1timore 10f. Zip Code 2123	39	10g.		Od. Inside City Limits 1 XYes 2 ☐ No
21215-0036	n 72 hours after d "natural", or item e ilical Evaninar i	Completed by Fun	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 ☒ Divorced 15. Decedent's E (Specify only highest gra	Armed Forces? 1 Yes 20 No If Yes, Give Year or Dates:	1 Yes 2 N		160	Black, White, Specify: Black Kind of Business/Inc	etc. ck
Maryland 212	iould be filed withir I Mental Hygiene. Parked other than hatic evant, ILE Mi	To Be Comp	17. Father's Name (First, Middle, Last, James Arthur Brya		upervisor		Fo (First, Middle, Maid	/	<u> </u>
Baltimore, Mary	Pages 1 and 2 sho ent of Health and I nt: If item 27 Is ma ry or other traums		19a. Informant's Name/Relationship (Antonio Pattillo 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	/ Son 19 20b. Place cemes 20c. Place cemes 20	9b. Mailing Address (Stre 0019 Katelyr of Disposition (Name of atery, crematory or other p view Cemeter	Dr., Char	lotte, N.	y or Town, State, Zip C. 28269 Location - City or To ederick, N	wn, State
Baltii	permit. Page Department of Important: If any injury or		21. Signature of Funeral Service Licen	C	22. Name and Add	dress of FacilityThe Hgts. Ave	Derrick C ., Baltim	. Jones F	/H, P.A. Land 21215
8760,	Physician and // / / / / / / / / / / / / / / / / /	Jicai Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence co. Due to (or as a consequence co. Due to (or as a consequence co.	LINFARC; ce of):		rrespiratory arrest,		Approximate Interval Between Onset and Death
P.O. Box 68	ires that the death certifica signed by the attending ph d be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown	ath 3 □Ectopic pregnar			23d. Date of delive Month	ory Day Year
Records, P	v requ been shoul	Completed by P	Part II. Other significant conditions of	contributing to death but not resulting	g in the underlying cause	given in Part I.		o use contribute to the	
Vital R	ding Physician: The lav h. After this certificate has funeral director, page 2	Be	25. Was case referred to medical examiner?	Hospital:		26. Place of Death	performed 1 ☐ Yes 2 2	death?	2X No
Division of	Attending Physic death. actor: After this of the funeral dir	Medical Certification: To	1	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At home,	b. Time of Injury M 1	jury at 2 fork? ☐ Yes 2 ☐ No	8d. Describe how in	and Number or Rura	
Ō	To the Hospital or Attendi within 24 hours after death. To the Funeral Diractor: A completely filled in by the fu	cal Cert	29a. Certifier 1X Certifying Ph	building, etc. (Specify) systicien: To the best of my knowled niner: On the basis of examination	dge, death occurred at the	time, date and place, a	City or Town, Sta	(s) and manner as st	ated.
	To the H within 24 To the F complete	Medi	one) 29b. Signature and title of certifier	and manner stated.	29c. Lice	nse number	29d. [Date signed (Month, I	Day, Year)
•	10		30. Name and address of person who	completed cause of death (Item 23:	a) (Type, Print)	059290	Ma	Rolling	2004
	Sta Regist		31. Date filed (Month, Day, Year) MAR 2 0 2004	32. Registrar's Signature	forks	aven Dows	evaral	vair more	- My 21231

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Deeth Month 1. Decedent's Name (First, Middle, Last) Dev **Physician** March 13 Mary Louise Passalacqua 2004 12:20 AM /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4e Fecility Neme (If not institution, give street end number) Examiner Stella Maris Hospice Timonium Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. lest birthday) 6 Sex Hours **Funeral** Months Days 1 □ M XX F 215-40-0818 65 July 17, 1938 Maryland Director Usuel Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. Stete 10b. County r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 🍇 No Director Maryland Harford Bel Air 10g. Cifizen of Whet Country? 10f. Zip Code 10e. Street end Number 502 Old Stone Place 21015 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 1KIX ever Married 2 Merried 1 ☐ Yes 2 ☐ No Specify Specify: δ 3 Widowed 4 Divorced Yeer or Dates: White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementery/Secondary (0-12) 12 Gift Wrapper Retail Sales 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) Be Agostino Vincenzo Passalacqua Louise (unk) Carraro 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Relationship (Type, Print) 502 Old Stone Place, Bel Air, Maryland 21015 Elissa C. Passalacqua / Sister injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Most Holy Redeemer Cem. 3-16-04 Paltimore, Maryland 21. Signature of Funeral Service Licensee McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, ause on each line. Approximate Interval Between 23a. Pert1. Enter the diseese, or composition shock, or heart failure. List only of Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical END STAGE LIVER DISEASE Panniner Due to (or as a consequence of) Examiner use as the bunal-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) attending physician tor use as the buria Physician/Medical Due to (or as a consequence of) 23b. Did tobecco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 3 ☐ Probably 4X Unknown 1 ☐ Yes 2 ☐ No þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Be Completed 1 Yes 2 X No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 NOther (Specify) HOSPICE Certification: To 1 Yes 2 No 28d. Describe how injury occurred 27. Menner of Death 28e. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? Injury 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No

Box 68760, Division of Vital Records, P.O.

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Depertment of Health Important: if Item 27

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Maryland

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MARY PASSALACQUA

be detached

The law requires that the death certificete be axecuted signed aftar death.

Director: After this certificete has been si
d in by the funerel director, paga 2 should i or Attending Physician: filled in by To the Hospital within 24 hours a To the Funeral Completely filled

4 - Homicide edicai

29a. Certifier (Check only one)

2 Accident

3 ☐ Suicide

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

investigation

6 Could not be determined

29b. Signature and title of dertifier

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

TIMONIUM, MD 21093

29d. Date signed (Month, Day, Yeer)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print)

TARIQ MAHMOOD DR. 31. Dete filed (1 9 2

Registrer's Signature

2300 DULANEY VALLEY RD.

DHMH 16 Rev 6/95

State Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 17 Day Month **Physician** Mary Catherine Perrine March 2004 7:15a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospital Center Westminster Carroll If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Oct 1 1920 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2♥F 83 Yrs. 184-14-6800 PA Director Usual Residence of Decedent 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits *show other traumatic event. The Mudical Examiner must be notified at Md Carroll Sykesville 1 XYes 2 No Directo 28a-1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7731 Carter Road 21784 USA 238 Completed by Funeral or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married aryland 21215-0036 1 Yes 2 No Specify: White Specify: 3X Widowed 4 ☐ Divorced Year or Dates: "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry then Elementary/Secondary (0-12) College (1-4or 5+) homemaker domestic 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 9 and Mental Edward Joseph McGovern Clara Malloy Pages 1 and 2 should ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judith L. Barnes (daughter) 7731 Carter Rd., Sykesville, Md 21784 altimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 0 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
1 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Importent: If any injury or once. All County Cremation 3-18-04 Sykesville, Md 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service License Day Jordh The KUUK P.O. Box 195 Sykesville, Md 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition VENTRICULAR **Physician** nistau /Medical resulting in death) Due to (or as a consequence of) Examiner U Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. by Physician/Medical as the IF FEMALE use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy 10 Month Day Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2 No detached the 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ed bluods 2 No 3 ☐ Probably 4 ☐Unknown Completed J-Cast 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s autopsy 1 Yes 2 No Hospital or Attending Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Unpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA funeral Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending Injury 1 ☐ Yes 2 ☐ No death. within 24 hours after death.

To the Funeral Director: A completely filled in by the form investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifie 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Chilalishi voganing DOO 18 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) pool 2d (IESTA) IS TER AD 91157 CHITAKITEDU 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 1 9 2004 Registrar

ORIGINAL

DHMH 17 Rev 1/2001

J. J.

State of Maryland / Department of Health and Mental Hygiene, Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2004 Month **Physician** 0010 a Benjamin March 13, Pena /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | March | Days | Hours | Min. | March | March | 22, 1928 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Colombia **Funeral** 1**X** M 2 ☐ F 76 547-68-9923 Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show r than "natural", or Items 23a or 28a-f shov the Medical Examinar must be notified at MD Montgomery Village XXYes 2 □ No Director Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9605 Shadow Oak Drive 20886 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene ant if Item 27 is marked other than "natural, or Item ury or other traumatic event, the Medical Exampar ury or other traumatic event, the Medical Exampa 1 Yes 2XXNo 1 Never Married 2 Married Baltimore, Maryland 21215-0036 XXYes 2 No Specify: þ If Yes, Give ***
Year or Dates: 3 Widowed 4 Divorced White Colombian Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Real Estate Management/ Elementary/Secondary (0-12) College (1-4or 5+) Real Estate 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Segundo Peno Lola Paez 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9605 Shadow Oak Drive, Montgomery Village, MD Maria Victoria Pena, Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1 Depertment of H Important: If Ite any injury or ot once. 1 Burial 2 □ Cremation 3 □ Removal from State All Souls Cemetery 3/16/04 Germantown, MD * 4 ☐ Donation 5 ☐ Other (Specify) Simple Tribute Funeral and Cremation Center 21. Sign ture of Frineral Service Licensee 1040 Rockville Pike, Rockville, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** n 6 Week Unionia resulting in death) /Medical Due to (or as a consequence of): Examiner tailure λa Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 4 Pregnant at time of death been signed by the should be detached ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 1 Yes 2 No of Vital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ 1√0 10 142Inpatient 2 ER/Outpatient 3 DOA After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: Division 1 Matural 5 Pending investigation death. М 1 ☐ Yes 2 ☐ No 2 Accident Director: , 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide after Hospital within 24 hours a 1 F Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Cneck only one) To the ! 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MA March, 13, D 051714 malion 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) & JATIN & ETC SEKHON 2401 Blud Rocker Ke earc Suite 104 31. Date filed (Month, Day, Year) 32..Registrar's Signature State Registrar 9 2004

		1	For State Registrar	State of Maryland		artment of Hetificate of E			Reg. No.	2004	
	Physicia /Medic	an al	1. Decedent's Name (First, Middle, Last) GEORG, E 4e. Fecility Name (If not institution, give s	PETE1	RS	4b. City, Town, or	Location of	2. Date of D Month MARCH	Day	Year	3. Time of Death
123	Examin Funeral		UNIVERSITY OF MARYLAN 5. Social Security Number 6. Sex	7. Age (In yrs. las		If Under 1 Year Months Days	MORE	4 Hrs. 8. Date of B			plece (State or Foreign
D	Director		216-30-7180		Town or Lo	cation		Aug. 4	, 1752		10d. Inside City Limits
the Maryla	r 28a-f eho	Director	Md. Harford			Fallston			10g. Citizen	of What Cou	1 □ Yes 2 No
:1215-0036 within 72 hours after death with the Maryland	Department of Health and Mental Hygiene. Important: If item 27 le marked other than "natural", or Itams 23a or 28a-f ehow any injury or other treumatic event, the Medical Exercitive fraust be notified at once.	ā	2607 Claret Drive 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No 1955	2	2104 Was Decedent of His f Yes, specify Cubar 1 ☐ Yes 2 및 No		n? (Specify Yes or N Puerto Rican, etc.)	10- 14.	ted St Race - Ameri Black, White ecity: W	can Indian,
Maryland 21215-0036	iene. rthan "natural" ine Medical Ex	Completed b	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0·12)	Year or Datest 0 1950 sation completed) College (1-4or 5+)	16a. Dece (Give life.	dent's Usual Occupa kind of work done d DO NOT use retired/ tems engit	lu <i>ri</i> ng most (of working		of Business/Ir	n systems
/land 2	Mental Hyg urked other itic event,	To Be C	17. Father's Name (First, Middle, Last) George A. Peters				Mart	s Name <i>(First, Middi</i> tha Jacot			
, Mary	alth and h		19a. Informant's Name/Relationship (Ty) Joan Peters/wife		260	7 Claret	Drive	or Rural Route Num , Fallstor	, Md.	21047	
Baltimore,	ant: If iten		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☑ Other (Specify)6		hview		s. 3,	Date /20/04	Falls	ton, M	d.
Balt	Departi Import any inj once		21. Signature of Funeral Service License	ellen	Ì	610 W. Ma	cPhai	ral Home o	1 Air.		
	hysician /Medical xaminer		23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Due to (or as a conseque	tic c		. 1				Interval Between Onset and Death
1760,	ysician and ne burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque							
Records, P.O. Box 68	been signed by the attending ph should be detached for use as tt	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnan 1 Live birth 2 Fetal of 4 Pregnant at time of dea	death 3	□Ectopic pregnancy □ Other (specify)			23d	. Date of delive Month	rery Day Year
rds, P.	n signed by		Part II. Other significant conditions con Diabetes Mellitu		iting in the u	nderlying cause give	en in Part I.		tobacco use		the cause of death?
	ate has page 2	Completed						24a. We au pe	opsy formed?	24b. Were aut prior to co death? 1 ☐ Yes	opsy findings available opposition of cause of 2 □ No
of Vita	certifi	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	lospital: 1 ⊠Inpatient 2 ☐ E	R/Outpatie	nt 3 DOA Othe	ar:	of Death (Check only sing Home 5 Re		Other (See	(ha)
ision of	fter f	ation: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation		28b. Time o	f 28c. injury Work		28d. Describ	e how injury o		
Divisi	vithin 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hon building, etc. (Specify)	me, farm, st	reet, factory, office			(Street and Nown, State)	lumber or Rui	al Route Number,
2	e nospi 24 hour e Funera letely filla	edical	29a. Certifier 1 Certifying Physics (Check only one) 1 Medical Exami	sician: To the best of my know ner: On the basis of examination and manner stated.	vledge, dear on and/or in	h occurred at the tim vestigation, in my op	ne, date and pinion, death	place, and due to the control of the time	e cause(s) an e, date and pl	d manner as ace, and due	stated. to the cause(s)
Š	Withir To th comp	W	29b. Signature and title of certifier	(-		29c. License				igned (Month	
	10		30. Name and address of person who co		23a) (Type	Drint)	6490	BALTIME		H 16, Z	
	Sta Regist	ate	RODERICK KREIST 31. Date filed (Month, Day, Year) MAR 19 201		ure	SEEENE	71145	JACTING		East 1 Garage See	1

			For State Registrar	State of	Maryland / Depa	artment of Hea	alth and Me	ental Hygi	ene 2004	08878
			Decedent's Name (First, Middle	e, Last)				2. Date of Death Month		3. Time of Death
	Physici /Medic		Margaret	Mary Pyc	ha			March	18. 2004	8:40 a. M
	Examin		4a. Facility Name (If not institution			4b. City, Town, or Loc	cation of Death		4c. County of Deeth	
			Manor Care F			Roseda				ore Co.
	Funeral		5. Social Security Number	6. Sex 7.	Age (In yrs. last birthday) Yrs.		lours Min.	8. Date of Birth (Month, Day,)	Year) 9. Birth	place (State or Foreign intry)
	Director		218-07-2524 Usual Residence of Decedent		85 Trs.			July 28.	1918 Penr	nsylvania
	/land		10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	Many Firsh	tor	Maryland Bal	timore Co.	Rose	dale				1 ☐ Yes 2 No
	h the	Director	10e. Street and Number			10f. Zip Code		109	g. Citizen of What Cou	ntry?
	th will	aiD	5224 Millfiel	d Road		212	237		United St	cates
	r dea	Funerai	11. Marital Status	12. Was Decede	ent Ever in U.S. 13.	Was Decedent of Hispa If Yes, specify Cuban, M	nic Origin? (Spec Nexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Ameri Black, White	can Indian,
36	s afte	by Fu	1 ☐ Never Married 2 ☐ Marri 3 🌠 Widowed 4 ☐ Divorced	If Yes Give	X No		pecify:		Specify:	White
21215-0036	n 72 hours after death with the Maryland "natural", or Items 23a or 28a-f show polcal Examiline must be notitled at	ed b	15. Deceden			dent's Usual Occupation	0	16	6b. Kind of Business/Ir	
15	드 교환	Completed	(Specify only highe	st grade completed)	(Give	kind of work done durin DO NOT use retired)	ng most of working	g	ob. King of businessin	idustiy
212	filed within Hygiene. ther than "ont, it a Mex	E	Elementary/Secondary (0-12)	College (1-4	or 5+)	Homemaker			Own Hor	ne
b	m = 0 =	Be C	17. Father's Name (First, Middle,	Last)		18.	. Mother's Name	(First, Middle, Ma	aiden Sumame)	
<u>la</u>	should be and Menta markad umaric ev	Jo.	Andrew Ciesi	elski			Constan	ce Sob	olesk	
Maryland	and and le m		19a. Informant's Name/Relations	hip (Type, Print)	19b. Maili	ng Address (Street and	Number or Rural	Route Number, (City or Town, State, Zi	o Code)
	s 1 and 3 f Heelth itam 27 other tr	13	Margaret A. Per	c / Daugh	ter522	4 Millfield			e, Marylar	
Ore	es of a		20a. Method of Disposition 1 Burial 2 □ Cremation	3 Removal from St	20b. Place of Dispo cemetery, cre	matory or other place)) I	ate 20	Oc. Location - City or T	own, State
Baltimore,	permit. Pag Department Important: I any injury o		*4 Donation 5 D0ther (S	pecify)	Oak Law	n Cemetery	March		Baltimo	
Bal	Depariment Department of the property of the p		21. Signature of Funeral Service	Michae		2. Name and Address of			5 Harford	
			23a. Part1. Enter the disease, or	complications that ceu		eonard J. F			timore, MD	21214 Approximate
8.			shock, or heart failure. List Immediate Cause (Final	only one cause on eac	h line.			,		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Due to (or	as a consequence of):	114				1PA1
С	Examiner				FRONIC (BSTRUCTIVE	E Ruci	Yorsey	DISCORE	•
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		as a consequence of):					
	te be executed ysician and te burial-transit	Examiner	that initiated events	С						
,097	e execian a		resulting in death) Last	Due to (or	as a consequence of):					
687	eath certificate be executed attending physician and for use as the burial-transit	dical		d						
	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as th	Physician/Med	IF FEMALE:	23c. If yes, outco	me of pregnancy				23d. Date of deliv	
Вох	atter for u	ciar	23b. Was decedent pregnant in the past 12 months?			Ectopic pregnancy Other (specify)			Month	Day Year
o.	at the de by the a	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknow						
٦,	es that igned k		Part II. Other significant condition	_	-		Part I.	23e. Did toba	cco use contribute to t	he cause of death?
Records,	w require been sig should b	Completed by	CHEGOVA	SCULAR	ACCID	LUIS		1 🗆 Yes	2	bably 4 Unknown
000	aw re	piet						24a. Was an autopsy	24b. Were auto	opsy findings available
H	The lav	E						performe	ed? death?	ompletion of cause of 2□ No
Vital	Physician: The this certificate heral director, page	Be	25. Was case referred to medica examiner?	1			. Place of Death	(Check only one)		
of V		2	1 ☐ Yes 2 ☐ 110		patient 2 ER/Outpatie	nt 3 DOA Other:	4 Nursing Hom	e 5 ☐ Residen	ce 6 □Other (Speci	fy)
	ding Ph h. After th funeral	on:	27. Manner of Death 1 ☐Natural 5 ☐ Pendir		Injury 28b. Time of Day Year) Injury	Work?		8d. Describe how	injury occurred	
isic	death. ctor: A y the fu	icat	2 ☐ Accident investi 3 ☐ Suicide 6 ☐ Could	not be an Blace of	Flaius, Athoma farm at		2 No	Of Location (Stre	ent and Number or Pur	of Pouts Alumbas
Division	or Al after of Direction by	Certification;	4 Homicide determ	nined 286. Place o	f Injury - At home, farm, st , etc. <i>(Specify)</i>	reet, ractory, office	2	City or Town,	et and Number or Run State)	ai Houle Number,
_	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.		29a. Certifier 1 ☐ Certifyir	ng Physician: To the b	est of my knowledge, deal	h occurred at the time, d	date and place, a	nd due to the cau	ise(s) and manner as s	stated.
	Ho Ho Fur fetely	Medicai	(Check only 2 Medical one)	Examiner: On the bas and manne	is of examination and/or in	vestigation, in my opinio	on, death occurre	d at the time, date	e and place, and due t	o the cause(s)
	To the within To the Comp	×	29b. Signature and title of certifie	r		29c. License nu			d. Date signed (Month,	
) Halve	10)		D3530	06	H	ARCH 18th !	2004
	3	1	30. Name and address of person		of death (Item 23a) (Type,	DSSSC Print) OK BULDIN	0	- 0		1
			DENNIS .H . OD		Rosewice Pr	ok bulwin	c , selité	1903 15.	ALTO. ND	21237
	Sta Registi		31. Date filed (Month, Day, Year) MAR 1 9	2004 Z Rec	gistrar's Signature					
DI	MH 17 Rev 1/2		mult T 9	2004	w & f	-				
,					ORIGIN	AL.				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 2004 Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Date of Death Month **Physician** 1:30 PM 2004 PUSIN March /Medical 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner BALTIMORE N/A ROLAND PARK PLACE NURSING HOME If Under 1 Year Months Days 8. Date of Birth Month, Pay, Year) 7. Age (In yrs. last birthday) If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1□ M 2 F Months Hours 86 NY Director 101-09-5953 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State show 10b. County r then "netural", or Items 23a or 28a-f show the Medical Examiner roughts notified at 1 Ves 2 □ No Director BALTIMORE MD N/A 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number 830 W. 40TH STREET #855 21211 U.S.A. death 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours efter ☐ Yes 2 No f Yes, Give 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced WHITE Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other then "ne any injury or other treumatic evant, the Medicons. Elementary/Secondary (0-12) College (1-4or 5+) SOCIAL WORKER JEWISH FAMILY SERVICES 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Lest) Be LEVITT **SCHAENAN** LILLIAN FRANK ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 830 W. 40TH STREET #855 - BALTIMORE, MD 21211 HERMAN PUSIN / HUSBAND 20b. Place of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🛚 Cremation 3 ☐ Removal from State HILLTOP SERVICE CORP. 3/18/04 TOWSON, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service License 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical unkuruh Examiner 11 Examiner ettending physician and for use as the buriel-trensit The law requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events Due to (or as e consequence of Division of Vital Records, P.O. Box 68760. Physician/Medicai Due to (or as e consequence of): resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of deeth? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Was en autopsy performed? Completed this certificate has page 1 Yes 2 No 1 □ Yes 2 □ No al or Attending Physician: To sefter death.

I Director: After this certificet ed in by the funerel director, pa 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Naturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 4 \(\text{Homicide} \) To the Hospital of within 24 hours of To the Funerel Discompletely filled in 10 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner es stated.

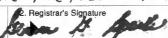
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Dey, Yeer) 29b. Signeture and title of certifier march 17, 2004 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

N. ISABELLE THEGREGOR, 830 IV 40 HL STREET, BALTIMORE, MD 21211

State

Registrar

31. Date filed (Month, Day, Year) 9 2004 MAR1



State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** III 2004 Marion Richter March 14, 12:04 A. Warner /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Frederick 4611 Delauter Road Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct. 27, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F 66 1937 Maryland 218-32-2355 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Importment: If it may 27 is marked other than "natural" ----any injury or other treasment. 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1 ☐ Yes 2 ▼No Frederick Frederick Maryland Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4611 Delauter Road USA 21702 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 ☐ No If Yes, Give 1 Never Married 2X Married White 1 ☐ Yes 2 XNo Specify: Specify: þ 3 Widowed 4 Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) County Government Chief Plumbing Inspector 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mary Marcia Huson Warner Marion Richter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4611 Delauter Road, Frederick, MD 21702 Barbara J. Richter/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 03-19-2004 Bel Air, MD Bel Air Mem. Gardens * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
McComas Funeral Home P.A.
50 W. Broadway Street, Bel Air, MD 21014 21. Signature of Fundal Service Licensee once. im 23a. Part 1. Enter the disease, or complicant shock, or heart failure. List only or shock is they caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, us neach line. Approximate Interval Between Onset and Death Immediate Cause (Final Me tastati Physician month 10 resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. the attending physician by Physician/Medical the use 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy ŏ in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed been : 24a. Was an autopsy performs 24b. Were autopsy findings available prior to completion of cause of death? has page 2 certificate 1 ☐ Yes 2 ☐ No 1□ Yes 2☑No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \(\tau \) Nursing Home 5 \(\textstyle \) Residence 6 \(\textstyle \) Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 2 ER/Outpatient Ē 1 Inpatient 3 DOA Certification; To this within 24 hours after death.

To the Funerel Director: After thi
completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Attanding 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No М 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide ō To the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D41619 March 15 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 63 Thomas Johnson Drive Frederick, Maryland Dr. Michael Lerner, M.D. 2. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 1 9 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 08881 For State Registra Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 1500 WuYun Ren March 15, 2004 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery Shady Grove Hospital Rockville | ROCKVILLE | If Under 14 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | May 13, 1 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 59 China Director 123-60-4507 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 28a-f show the Medical Examiner must be notified at XXXYes 2 No Germantown Montgomery Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ö United States 12518 Timberhollow Place 20874 "natural", or Itams 23a Completed by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 XXVIIII If Yes, Give Year or Dates: 1 Never Married XXMarried Specify: Asian Baltimore, Maryland 21215-0036 1 ☐ Yes 2\(\times\)\(\times\)\(\times\) Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed withit Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumeric. College (1-4or 5+) Elementary/Secondary (0-12) Chemist Chemistry +4 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be PuChih Ren Ming Hui Ren ٥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 12518 Timberhollow Place, Germantown, MD 20874 Shi Yuan Ren, Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Baltimore Crematory at LP 3/17/04 Baltimore, MD * 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility

imple Tribute Funeral and Cremation Centur

1040 Rockville Pike Rockville, MD 20852 21. Signature of Funeral Service Licenses 23a. Phrt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 2 Weeks Physician Small Bowel Obstruction disease or condition /Medical resulting in death) Due to (or as a consequence of): Examiner 3 Years Cancer of Pancreas Satuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed use as the burial-tran and Due to (or as a consequence of) Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy detached for u Month Year in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 99 1 ☐ Yes 2 ☐ No 3 ☐ Probably XXUnknown Neutropenia page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 1 Yes 2 No or Attending Physician: 26. Place of Death Check on one 25. Was case referred to medical examiner? Certification: To Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1XXnpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident hours after deat 6 □ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) þ 4 Homicide within 24 hours : To the Funeral I pelli 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only onel 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D21243 March 18, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 18111 Prince Philip Drive, Olney, Md 20832 Dr. David Newsome 2. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 1 9 2004 Registra DHMH 17 Rev 1/2001

		1 - For State Registrar 1. Decedent's Name (First, Middle, Last)	State of Marylan	d / Depa <i>Cer</i>	rtment of F	lealth and Death	Mental Hyg R 2. Date of Dea	eg. No.	04 08882
Physic /Med Exam	ical	James M 4a. Facility Name (If not institution, give s	street and number)			r Location of Deat	MARCH	Day	Year 9:58 PM of Death
Funera Directo		5. Social Security Number 118-40-5667 6. Sex			If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, Day		timore City 9. Birthplace (State or Foreign Country) New York
Maryland a-f show	tor	Usual Residence of Decedent 10a. State 10b. County MD Montgo		y, Town or Loc Germa					10d. Inside City Limits 1XXYes 2 □ No
ath with the Marylan s 23a or 28a-f show and be redilined at	Funeral Director	10e. Street and Number 17804 Cricket Hil	1 Drive		10f. Zip Code 208	74	1	Og. Citizen of W Unite	hat Country? d States
after de or Items	þ	11. Marital Status 1 □ Nøver Married 2 □ Married 3 □ Widowed 4 ☒ Divorced	 12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 XXIo If Yes, Give Year or Dates: 	lf If	Vas Decedent of H Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)		- American Indian, K, White, etc. White
within 72 hours ene. then "natural", its Mudical Exe	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4or 5+)	(Give I life. D	ent's Usual Occup kind of work done O NOT use retired nior Mana	during most of wor d)	rking	16b. Kind of Bus	siness/Industry nal Revenue rvice
be filed ital Hygi d other	To Be Co	17. Father's Name (First, Middle, Last) James Vincent Ru	sso	36	IIIOI Mana	18. Mother's Nar	n <i>e (First, Middle, M</i> eth Hartm	Maiden Sumame	
s 1 and 2 should if Health and Men Item 27 is marke other traumatic		19a. Informant's Name/Relationship (Type Paul Russo, Broth 20a. Method of Disposition	er	3 Car	avan Cou	rt, East	Northpor	t, NY	11731
it. Page intment o intant: If njury or		1 ☐ Burial 2 ⚠ Cremation 3 ☐ R. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License	Ba	ltimor	ition (Name of atory or other place Cremato	ory at LI	9/04	Baltimo:	
perm Depa Impo		23d. Part I. Enter the disease, or complishock, or heart failure. List only on	cations that caused the death e cause on each line.		JAO ROCKT	<i>r</i> ille Pik	<u>te Rockvi</u>	lle, MD	ion Center 20852 Approximate Interval Between
Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	DILATED Due to (or as a consequence of the Nile)	uence of):			J.		Onset and Death
icate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of the Consequence of t	uence of): ansp (uence of):					
w requires that the death certific been signed by the attending p should be detached for use as I	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3 🗌	Ectopic pregnancy Other (specify)	,		23d. Date Mont	of delivery th Day Year
requires that ineed by hould be detailed	₽	Part II. Other significant conditions con	tributing to death but not resu	ulting in the un	derlying cause give	en in Part I.	23e. Did tob 1 ☐ Ya		bute to the cause of death?
The lay ate has page 2	Completed						24a. Was ar autops perform 1 🗇 Yes 2	ned? de	ere autopsy findings available for to completion of cause of sath? Yes 2 12 No
sir dia	To Be	TUTES ZEPNO	ospital: 1 Inpatient 2	ER/Outpatient		er: 4 □ Nursing H	th <i>(Check only one</i> ome 5 ☐ R <i>e</i> side		r (Specify)
Attending P death. octor: After I	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - At ho	28b. Time of Injury me, farm, stre		/ at k? Yes 2 □ No	28d. Describe ho		d r or Rural Route Number,
To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After the completely filled in by the funera	edical Certi	29a. Certifier 1 Certifying Phys	building, etc. (Specify ician: To the best of my knower: On the basis of examinate	v) wiedge, death	occurred at the tim	ne, date and place	City or Town	, State)	ner as stated
To the P within 24 To the F complete	Medi	29b. Signature and title of certifier	and manner stated.		200 1 10000	number.	T 20	Net alered	March Co. Vess
ll		30. Name and address of person who col	noleted cause of death /learn	23a) (Tuno 5	PI	7657	M	ARCUI	1,2004 Land 2120
n		30. Name and address of person who col Re BCCCA MANN 31. Date filed (Month, Day, Year)	C / M D 22	South	Greene	Street	BALTIMO	u, MARY	Land 21201
S: Regis	tate trar	31. Date filed (Month, Day, 1ear)	32 Registrar's Signat	4	ieth 1				

			1 - For State of Maryland / Department	artment of Health and Mertificate of Death	lental Hygie	2011	08883
	Physic /Medi Examii	cal	Decedent's Name (First, Middle, Last) MAURICE 4a. Facility Name (If not institution, give street and number)	ROTTENBERG 4b. City, Town, or Location of Death	2. Date of Death	Day Year	3. Time of Death 4:15 A
	Funeral Director		HOSPICE OF BALTIMORE GILCHRIST CENTER 5. Social Security Number 216-30-1424 6. Sex 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday)		8. Date of Birth (Month, Day, Ye OCT.11,1	9. Birth	IMORE place (State or Foreign untry) MD
•	ified within 72 hours after death with the Maryland Hygiene. Whysiene. Wher than "natural", or Iteme 23a or 28a-1 ehow ent, the Medical Exament must be notified at	I Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Low MD BALTIMORE BALT 10e. Street and Number 217 GAYWOOD ROAD	TIMORE 10f. Zip Code 21212	10g.	Citizen of What Cou	10d. Inside City Limits 1 ☐ Yes 2 ☐ No untry? U.S.A.
90038	n 72 hours after death "natural", or Iteme 2	ted by Funeral	11. Marital Status 1 Never Married 2 X Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates: 15. Decedent's Education 16a. Dece	Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:	166	14. Race - Amer Black, White Specify: b. Kind of Business/li	ican Indian, , etc. WHITE
Maryland 21215-0036	be filed within 7 tal Hygiene. Id other than "ne event, the Medi	Be Completed	Elementary/Secondary (0-12) College (1-4or 5+) 4 ACC 17. Father's Name (First, Middle, Last)	o kind of work done during most of working DO NOT use retired) COUNTANT 18. Mother's Name		CCOUNTING	
		٦ و	19a. Informant's Name/Relationship (<i>Type, Print</i>) 19b. Mailie NANCY LARK SCHULZE / WIFE 217	FENBERG MARY Ing Address (Street and Number or Rural GAYWOOD ROAD - BAL			MILLER p Code)
	permit. Pages 1 and Department of Healt Important; If item 2 any injury or other Once.		*4 Donation 5 Other (Specify) DRUID RID	matory or other place)	/2004	PIKESVILI	E, MD
14 4:15 Am	Physician /Medical Examiner penual-transit	al Examiner		3900 REISTERSTOWN F	ROAD - PI		
0 4	that the death certificate of by the attending phys detached for use as the	Physician/Medical		□Ectopic pregnancy □ Other (specify)		23d. Date of deliv	ery Day Year
	e law requires has been sign je 2 should be	Completed by Pt	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacc 1) Yes 24a. Was an autopsy performed	24h Were autr	the cause of death? bably 4 Unknown posy findings available impletion of cause of
Maurille Rottenber	or Attending Physician: after death. Director: After this certification by the funeral director.	Certification; To Be Co	25. Was case referred to medical examiner? 1 Yes	of 28c. Injury at 2 Work? M 1 □ Yes 2 □ No	1 Yes 2	No 1 Yes 6 COther (Special Conjury occurred	m Hospice
Mar	To the Hospitel or within 24 hours afte To the Funerel Dir completely filled in	Medical C	29a. Certifier (Check only one) 1 ▶ Certifying Physician: To the best of my knowledge, deatt 2 □ Medical Examiner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occurre	ed at the time, date a	and place, and due t Date signed (Month,	O the cause(s) Day, Year)
	6		30. Name and address of person who completed dause of death (flesh 23a) (Type, W. A. R. Ley C. S. M. G. Z.		St. B.	Aveh 16 alks. M.	120207
	Sta Regist		31. Date filed (Month, Day, Year) MAR 1 9 2004 2. Registrar's Signature	le			

			1 - For Amend Item 23a pe	State of Maryla	nd / Dep /04dhb	artment of rtificate of	Health and f Death	Mental Hygi	ene20	04	08884
			1. Decedent's Name (First, Middle, Last	· · · · · · · · · · · · · · · · · · ·				2. Date of Death Month	1		3. Time of Death
	Physic /Medi		MILDRED	RIGBY				. 3	Day 2	Year O 4	10127PM
*	Exami		4a. Facility Name (If not institution, give			4b. City, Town,	or Location of Dea	ith	4c. County	of Deeth	
			BON SECOURS			BALTIM			L	NA	
(tts.	Funeral Director		5. Social Security Number 6. Se 218 - 22 10706 Usual Residence of Decedent	x 7. Age (In yrs	. last birthday) Yrs.	If Under 1 Yea Months Days		. (Month, Dey,	Yeer) 120	9. Bifthpla Counti	ace (State or Foreign ny) MD
	Aaryland ahow	o.	10a. State 10b. County		ity, Town or Le					10	d. Inside City Limits
	28a-1	Funeral Director	10e. Street and Number	DH	LTIMOR	10f. Zip Code		10	g. Citizen of W	/hat Count	
	3a or	ā	1819 PRESSTMAN	ST.		212	17		11<	SA	.,,-
	death	nera	11. Marital Status	12. Was Decedent Ever in I	U.S. 13.	Was Decedent of	Hispanic Origin? (Specify Yes or No- rto Rican, etc.)		- America	
920	72 hours after death with the Maryland natural', or tlems 23a or 28a-f ahow alsel Examirer must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 🖄 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 M.No If Yes, Give Year or Dates:	ĺ	1 ☐ Yes 2 💆 No		no Hican, etc.)	Specify:	k, White, e	- 4 -
215-0036	- 30	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	lication le completed) College (1-4or 5+)	(Give	DO NOT use retir	e during most of wo ed)	orking 1	6b. Kind of Bus		,
2	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, the Ma	Con	12 TH GRADE	NA	Hon	NE MAK	KER		DO	MEST	10
Ind	tal Hydral Hydral Hydral Hydral	Be	17. Father's Name (First, Middle, Last)	·				ame (First, Middle, M	aiden Sumame	e)	
<u>S</u>	d Men d Men narke	10	JAMES KING		10			PIERSON			
Maryland	d 2 st th and 7 Is n traun		19a. Informant's Name/Relationship (7) RODNEY RIGBY.		19b. Maili	ng Address (Stree		iural Route Number,			
	1 and Health tem 27		20a. Method of Disposition		Place of Dispo	osition (Name of		Y. BALTO	Oc. Location - 0	City or Tow	m. State
Baltimore,	permit. Pages 1 and. Department of Health Important: If Item 27 any injury or other tr angoe.		1 Burial 2 Cremation 3 ☐F 14 ☐ Donation 5 ☐ Other (Specify)	Removal from State	cemetery, crei	matory or other pl	ace)	09-04 L			
alti.	permit. Pag Department Important: any injury o		21. Signature of Fugeral Service License					the state of the s		, 1110	
B	Depariment of the part of the		Waugh (I		YA	LIGHN C.	GREENE F	PUNDRAL SE	PRICE 2	11229	
)	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition	ications that caused the deane cause on each line.		ter the mode of dy		c or respiratory arres		10	Approximate nterval Between Oncet and Death -20 mln
R.	/Medical		resulting in death)	Due to (or as a conse	quence of):						vears
7 5.	Examiner		Sequentially list conditions,	· Cardo	in f	Arteriosc	ierotic He	art Disease		10	to Us
	ed isit	lne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	quence of):						
,092	ate be executed hysician and the burial-transit	il Examiner	that initiated events resulting in death) Last	Due to (or as a conse	quence of):					+	
687	physic the t	dlcai	•	d							
P.O. Box 6	Physician: The law requires that the death certifica this certificate has been signed by the attending phral director, page 2 should be detached for use as the	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	aldeath 3[□Ectopic pregnand □ Other (specify) _	су		23d. Date Mont	of delivery	/ lay Year
	that led by deta	y Ph	Part II. Other significant conditions co	ntributing to death but not re	sulting in the u	nderlying cause g	iven in Part I.	23e. Did toba	cco use contrib	bute to the	cause of death?
Records,	quires n sign	Q D	anemia					1 ☐ Yes	200 No 3	3 🗌 Probab	oly 4 Unknown
00	s been si	Completed						24a. Was an	24b. W	ere autops	sy findings available
Re	ysician: The lav is certificate has director, page 2	E						autopsy performe	ed? de	for to comp eath? ☐ Yes 2	oletion of cause of
Vital	ien: rtifica stor. p	Be C	25. Was case referred to medical				26. Place of De	1 Yes 25 ath (Check only one)			
of V	Physic this ce al direc	To	examiner? 1 ☐ Yes 2 ☑ No	lospital: 1 ☐ Inpatient 2 ☐	ER/Outpatier	at 3 X DOA Ot	ther: 4 Nursing I	Home 5 Residen	ce 6 Other	(Specify)	
n o	ting Pl		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	f 28c. Inju	iry at ork?	28d. Describe how			
<u>S</u> .	Attending r death. ctor: After by the fune	catl	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 No				
Division	ital or Attendi rs after death. rel Director: A led in by the fu	Certification;	4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ify)			28f. Location (Stre City or Town,	State)		
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier 1. Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of my kn ner: On the basis of examin- and manner stated.	owledge, death ation and/or in	h occurred at the t vestigation, in my	me, date and place opinion, death occ	e, and due to the cau urred at the time, date	se(s) and mani e and place, an	ner as stat nd due to th	ed. ne cause(s)
	To the Within 3 To the comple	Σ	29b. Signature and title of certifier	0 :		29c. Licen	se number	290	d. Date signed		y, Year)
	0		Salvatore 1	aiti		D 00	12753		3/2/0	04.	
	0		30. Name and address of person who co				L- n	,			
87	Sta	te	31. Date filed a Morth, Pay Year	12 Registrarts Sign	ature	An- d	to-SPITA	<u></u>			
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			_	State of Maryla				•	-	
			1 - For State Registrar	•		tificate of			9. No. 2 U U 4	08885
	Physici		Decedent's Name (First, Middle, Last) JOSEPH GI	LMOR ROWLEY	SR			2. Date of Death Month Morch	Day Year	3. Time of Death
	/Medio Examir		4a. Facility Name (If not institution, give s	street and number)		4b. City, Town, o	or Location of Death	1001	4c. County of Dea	
				oltimore	- 1	Baltine	- 0		N/A	
	Funeral Director		5. Social Security Number 6. Sex 212-01-1079 XX	7. Age (in yr.	s. last birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, 1 August 27,	rear) 9. Bir 1915 Mar	thplace (State or Foreign ountry) Yland
	yland		10a. State 10b. County	10c. C	City, Town or Lo	cation				10d. Inside City Limits
	Be-fel	Director	Maryland Baltimor	e To	wson					1 ☐ Yes X No
	death with the Maryland ms 23a or 28e-f ehow rimat be notified at		7925 York Road			10f. Zip Code 2120	04	109	g. Citizen of What Co USA	ountry?
	within 72 hours after death with the Marylan ane. Than "natural", or Items 23a or 28e-f show na Madical Examinat must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married X ★ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 Dives 2 □ No W If Yes, Give Year or Dates:	WII	Vas Decedent of H Yes, specify Cuba	tispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit Specify: Will	e, etc.
3-003e	72 hou	ted	15. Decedent's Educ (Specify only highest grade	cation	16a. Deced	lent's Usual Occup	eation during most of worki	16	6b. Kind of Business	
7		Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	OO NOT use retired	d)	ng	Furniture	
7 00	be filed withing tel Hygiane. d other than event, the M		17. Father's Name (First, Middle, Last)		Buye		18. Mother's Name	(First, Middle, Ma		
=		To Be	Gilmor 19a. Informant's Name/Relationship (Ty)		wley	a Address (Street	Margare	et	Schl	eupner
<u>8</u>	5 5 5 € 5	ĺ	Jospeh G Rowley Jr	Son			and Number or Rura 11 Road Fr			
e,	of Hea	3	20a. Method of Disposition	20b.	Place of Dispos	sition (Name of natory or other place	ce)		c. Location - City or	
Daitimo	Page ment lent: It	1 5	1)☐(Burial 2 ☐ Cremation 3 ☐ Re 14 ☐ Donation 5 ☐ Other (Specify)	Ne	w Cathe	dral Ceme	etery 3/20		ltimore,	
מפ	permit. Pages 1 Department of H Importent: If Ite any Injury or ott once.		21 Signature of Funcial Service License	Man bi	7 22.	Name and Addre	ss of Facility Mit			
		-	23a. Part 1. Enter the disease, or compliant shock, or heart failure. List only on	ations that caused the dec	eth. Do not ente	er the mode of dyin	ng, such as cardiac o	KOAD BAIT: r respiratory arres	imore, Maryl	Approximate
. 4	nysician		Immediate Cause (Final disease or condition	Cerebrova						Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conse						ic ag
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	quence of):					
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00	ficate physics the		d							
y DOX	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 54 hours after death. To the Funnel Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medi	in the past 12 months?	3c. If yes, outcome of pregr 1 □ Live birth 2 □ Fel 4 □ Pregnant at time of 9 □ Unknown	tal death 3 🗆	Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year
Ċ	that the ed by the detach	Phy	9 ☐ Unknown Part II. Other significant conditions con-	tributing to death but not re	sulting in the un-	deriving cause give	en in Part I.	23e. Did tobac	cco use contribute to	the cause of death?
SO O	n slgn uld be	d b	Hypertension					1 ☐ Yes	V 1	obably 4 Unknown
2	law rec as bee 2 shor	Completed by	Non Insulin Dep	rendent Die	abetis	Kelli	itus	24a. Was an autopsy	24b. Were au	topsy findings available completion of cause of
	: The cate ha	Com						performe	d? death? ≹No 1 ☐ Yes	\$.
5	sician certifi rector	Be c	25. Was case referred to medical examiner?	ospital:	Jeno	3C DOA Otho	26. Place of Death			
5	ding Phys h. After this funeral di	ton; To	1 ☐ Yes 2 ☒ No ''' 27. Manner of Death 1 ☒ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injun	/ at 2	ne 5 ☐ Residend 8d. Describe how	e 6 □Other (Specinjury occurred	ify)
	Attence or death rector: by the	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec	home, farm, stre		Yes 2 □ No	8f. Location (Stree City or Town, S	et and Number or Ru	ral Route Number,
5	pitei or ours aft erel Di illed in		29a. Certifier 112 Certifying Physi							
	ne Hos n 24 ho ne Fun eletely f	Medicai	(Check only Z Medical Examin	ician: To the best of my kn er: On the basis of examin and manner stated.	ation and/or inve	occurred at the time estigation, in my of	ne, date and place, a pinion, death occurre	nd due to the caus d at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
1	withir To the Comp	×	29b. Signature and title of certifier	GITA		29c. License	number	29d	Date signed (Month	, Day, Year)
	0/		& Bradous koe	1.42	AUSKA ITE	RES	- 000	Ke	rch 17	, 2004
	8		30. Name and address of person who cor		m 23a) (Type, P	pital a	of Bolt	rîmore		
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature	(1000			
	Registr	ar	WAR 1 9 2004	Series	9 1	Can We 1				

DHMH 17 Rev 1/2001

tatient known as Joseph Rowley

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

O			For State Registrar	State of Maryland		artment of H			jiene 	necec
	Physicia /Medic		1. Decedent's Name (First, Middle, Las	Marie Stok		inoato or i		2. Date of Dea Month March	th Day Yeer	3. Time of Death
8.8	Examin		4a. Fecility Name (If not institution, give University Hospit 5. Social Security Number 6. S	al ax 7. Age (In yrs. Ia		4b. City, Town, o Baltime If Under 1 Year Months Days		8. Date of Birth	4c. County of Deat	
学 :	Director	4	Usuel Residence of Decedent 10a. State 10b. County		Yrs.	cation	riouis Mail	Apr. 2		10d. Inside City Limits
215-0036	be filed within 72 hours after death with the Maryland that Hygiene. Id other than "natural", or liems 23s or 28s-f ahow event, the Medical Examiner must be mailied at	Completed by Funeral Directo	10e. Street and Number Sp 11	12. Was Decedent Ever in U.S Armsd Forces? 1 Yes 2 2 No If Yes, Give Year or Dates: ucation de completed)	16a. Decec		Specify: ation during most of wo	Specify Yes or No- to Rican, etc.)	14. Race - Ame Black, White Specify: But 16b. Kind of Business:	intry? rican Indian, e, etc.
e, Maryland 2121	nit. Peges 1 and 2 should be filed within ordment of Health and Mental Hygiene. carent: If item 27 is marked other than injury or other traumatic event. The Mes.	To Be Co	NINGEL INTING	this on Durghty	19b. Mailir	ng Address (Street	18. Mother's Na	ural Route Number	Maiden Sumame) r, City or Town, State, 2	Tip Code) Z/23 j
Baltimore,	permit. Peges 1 Department of H Importent: If itse any injury or oth		20a. Method of Disposition **Seurial 2 Cremation 3 **4 Donation 5 Other (Specification 2) 21. Signatur Funeral Service of the disease, or compared to the disease, or compared to the disease, or compared to the disease, or compared to the disease, or compared to the disease, or compared to the disease, or compared to the disease, or compared to the disease, or compared to the disease, or compared to the disease, or compared to the disease.	Removal from State	UTUS /	MODENTIAL / Name and Addre	ss of Facility A	23/04 B	20c. Location - City or ABUTUS MANNI'S FOR	englaw
8760,	Physician /Medical Examiner physician and physician and physician and street physician in the private physician phys	dical Examiner	shock, or head failure. List only Importate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Johnshing Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence)	ence of):	njin	ع			Interval Between Onset and Death
P.O. Box 68	that the death certificati ed by the attending phy detached for use as the	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 MNo 9 □ Unknown	23c. If yes, outcome of pregnar 1 Live birth 2 Fetal 4 Pregnant at time of de	death 3	Ectopic pregnancy	1		23d. Date of del Month	ivery Day Year
	The law requires ate has been sign page 2 should be	Completed by Ph	Part II. Dther significant conditions o	ontributing to death but not resu	lting in the u	nderlying cause giv	en in Part I.	1 You	an 24b. Were au	obably 4 Unknown attopsy findings available completion of cause of
Division of Vital Records,	ding Physicien: After this certific funeral director,	ertification: To Be C	25. Was case referred to medical examiner? 1 XYes 2 No 27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time of Injury	Wor	er: 4 🗌 Nursing I		ence 6 Other (Spe	about b
Divis	To the Hospitel or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical Certific	(Check only 2 Medical Exar	28e. Ptace of Injury - At hos building, etc. (Specify ysicien: To the best of my knowniner: On the basis of examinat	me, farm, gr OAO vledge, deatl	eet, factory, office	ne, date and place	Baltono e, and due to the c	ause(s) and manner as	ral Route Number Auc. Amor. 1 Scii. Auc. stated. to the cause(s)
)	To the Vithin 2 To the Complet	Med	29b. Signature and title of certifier 30. Name and address of person who	and manner stated.	23a) (Tune	29c. Licens O.C.M			29d. Date signed (Mont March 16, 2	
	Sta Registr		31. Date filed (Month, Day, Year)	A			Street,	Baltimo	re, Maryla	nd 21201

ORIGINAL

				State of Ma						-	•	Die.	
			1 - For State Registrar	0.0.0 0	a. y tarra		rtificate				g. No. 20	04	08887
	Physicia	an.	1. Decedent's Name (First, Middle,	Last)						2. Date of Deat Month	h Day	Yeer	3. Time of Death
	/Medic	al	Joseph I. She							March 1		-15	9:30 A M
	Examin	er	4a. Facility Name (If not institution, 1075 Carriage H				,	m, or Location	n of Death		4c. County		ada 1
	Funeral			6. Sex 7. Ag	e (In yrs. la:	st birthday)	If Under 1 Y	apolis		8. Date of Birth	Anne		ICEL place (State or Foreign ntry)
	Director		007-07-8178	12XM 2□F .	76	Yrs.	Months D	ays Hours	Min.	(Month, Day, 7-21-19		Mair	
	and w		Usuel Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	ocation		<u> </u>			1	0d. Inside City Limits
	Maryl	tor	Maryland Anne	Arundel		λnns	apolis						1 ☐ Yes 2 📉 No
	in the	Director	10e. Street and Number	HUIGCI		Anne	10f. Zip Co	de		1	0g. Citizen of V	What Cour	ntry?
	death with the Maryland me 23a or 28a-f show ritual be notified at	rai	1075 Carriage H					1401				USA	
	ter de:	by Funeral	11. Maritat Status 1 □ Never Married 2 ☒ Marrie	12. Was Decedent I Armed Forces? d 1 X Yes 2 ☐ N		. 13.	Was Decedent If Yes, specify	of Hispanic C Cuban, Mexic	origin? (Spe an, Puerto I	cify Yes or No- Rican, etc.)		e - Americ ck, White,	can Indian, etc.
8	hours after tural', or its	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		52	1□Yes 2🎇	No Specif	y:		Specify	Whi	.te
ည်	n 72 hours after death with the Marylan "natural", or iteme 23a or 28a-f show edical Examiner itual be nutified at	Completed	15. Decedent's (Specify only highest	Education grade completed)		(Give	dent's Usual O	one during me	ost of workii	ng	16b. Kind of Bu	siness/în	dustry
2	within 72 ene. than "nat	Idm	Elementary/Secondary (0-12)	College (1-4or 5	5+)		<i>DO NOT use r</i> entist	etired)			Det	ntal	
Maryland 21215-0036	Hygi Hygi ent, I	Be Co	17. Father's Name (First, Middle, L.				MILISE	18. Mot	her's Name	(First, Middle, M			
<u>lan</u>		To B	Israel S	nevenell						IM.	Marion H	Зоу	
a	2 should and Men is marke sumatic	•	19a. tnformant's Name/Relationshi			19b. Mailir	ng Address (Si	reet and Num	ber or Rura	Route Number,	City or Town,	State, Zip	Code)
	s 1 and 2 should 1 Health and Mer Item 27 is marke other traumatic		Marlene J. Sheve	<u>enell/ Daug</u> l	nter	3224	Harne	ss Cre	ek Rd	Annar	olis, N	4D 21	403
Baltimore,	permit. Pages 1 and Department of Heal Important: If Item 2 any injury or other once.		1 ☐ Burial 2 💆 Cremation :			netery, cren	sition (Name on atory or other Cremato	place)	3–16-		Edgewat		
	permit. P Departme Importan any injur		21. Signature of Funeral Service								Kalac I	Junor	al Home
m —	Deparil Deparil Importany ir		> /4mmvil	let-		29	73 Sol	omons :	Island	Road,	Edgewat	ter,	Md. 21037
۶			23a. Part1. Enter the disease, or c shock, or heart failure. List o	nly one cause on each lir	ne.			, .			est,		Approximate Intervat Between Onset and Death
	Physician /Medical		tmmediate Cause (Final disease or condition resulting in death)	a. Due to (or as	onge	2571	ve H	cart	fa	ilure			34-5
23	Examiner			Due to (or as	a conseque	ince or):							
1	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a conseque	ince of):							
	te be executed ysician and te burial-transit	Examiner	Cause (Diseese or injury that initiated events resulting in death) Last	cDue to (or as	a conseque	nnce of):							
9,	e be ex /sician e buria	calE		d									
89	tificate ig phys as the			0.									
Box	leath certificat attending phy I for use as the	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 □ Live birth			Ectopic pregn	ancy			23d. Dat	e of delive	ory Day Year
o.	The law requires that the death certifica site has been signed by the attending ph page 2 should be detached for use as th	Physician/Medi	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□ Pregnant at 9□ Unknown	time of dea	ith 5□	Other (specif	/)			10101	101	Day Toal
ع	w requires that the dibean signed by the should be detached	y Ph	Part II. Other significent condition	s contributing to death b	ut not result	ing in the u	nderlying caus	given in Par	t 1.	23e. Did tob	acco use conti	ribute to th	ne cause of death?
Records,	quires an sign	ed by				1				1 ☐ Ye	s 2 110	3 Prob	ably 4 □Unknown
ဝင္ပ	law re as ber 2 sho	Completed								24e. Was ar	24b. V	Nere auto	psy findings available inpletion of cause of
	Physician: The lav this certificate has al director, page 2	Con								perform	1ed?_ c	death?	
Vital	sician certifi rector	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:		B/O		Othor		(Check only one			
ō	g Phyl er this eral di		27. Manner of Death	28a. Date of injur	ry 2	8b. Time of	t 3 □ DOA 28c.	4 □ Injury at Work?		ne 5 Describe ho			/)
loi Oi	anding ath. or: Afte	atio	1 Natural 5 Pending 2 Accident investiga		y rear)	Injury	м	work? 1 Tes 2	□No				
Division of	or Atter de line de line by ti	Certification:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	28e. Place of Inju- ed building, etc	ury - At hom c. (Specify)	ne, farm, str	eet, factory, of	ice	2	8f. Location (Str City or Town	reet and Number, State)	er or Rura	l Route Number,
	To the Hospital or Attending Physician: white 24 hours after death as a first death or the Funeral Director. After this certifies completely filled in by the funeral director, it		29a. Certifier 1 Certifying	Physician: To the best	of my knowl	edge, death	occurred at the	ne time, date a	and place, a	nd due to the ca	use(s) and ma	nner as st	eted
	n 24 h n 24 h he Fur	Medical	(Check only 2 Medical E	kaminer: On the basis of and manner sta	f examinatio	on and/or inv	vestigation, in	ny opinion, de	ath occurre	d at the time, da	ite and place, a	and due to	the cause(s)
	withi To tl	Σ	29b. Signature and title of certifier	04				cense number			d. Date signed		
					1			5181	7	C delication of the control of the c	5/15	104	/
ľ	V		30. Name and address of person w	. malta	13	32 H	Fulida D	CT	5-17	te 201	Ann	pu 1/3	MD
	Sta Registr		31. Date filed (Month APR. Year)	2004 32 Pagistra	ar's Signatu	* A	18462						

			For State	State of Maryland / Department of Health and	Mental Hygiene	2001 00000
			Registrar 1. Decedent's Name (First, Mjddle, Last)	Certificate of Death	Reg. No. 2	3. Time of Death
	Physici /Medic		Alexander	Sgibnev	March 16	2004 5:00 A.M
	Examin		4a. Facility Name (If not institution, give s	street and number) Apt 4b. City, Town, or Location of Dea	th //s 4c. C	Battimore Co.
	Funeral		5. Social Security Number 6. Sex	Months Days Hours Min		9. Birthplace (State or Foreign Oountry)
	Director		Usual Residence of Decedent	M 2LF // Yrs.	5-1-193	25T Kussia
	Maryland f show fied al	tor	10a. State 10b. County Ra/47	more Co. Owings Mills		10d. Inside City Limits 1 ☐ Yes 2 No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "netural", or Items 23e or 28e-f show any injury or other treumatic event, the Madical Examinational to notified at once.	Funeral Director	10e. Street and Number 104 Pleasant	- Ridge Dr. APT. 101. Zip Code	10g. Citize	on of What Country?
	ems 23	nera	10 / -	12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (I. Race - American Indian, Black, White, etc.
980	urs afte	by	1 ☐ Never Married 2 Married 3 ☐ Widowed 4 ☐ Divorced	1	S	ipecity: White
15-0036	"netur	leted	15. Decedent's Edu (Specify only highest grade		orking 16b. Kind	d of Business/Industry
2121	filed within Hygiene. other then "out, the was	Completed	Elementary/Secondary (0-12)	College (1-40r5+) Assembly Line	vorker Tru	nck Manut.
and	d be filed ntal Hygie ed other:	36	17. Father's Name (First, Middle, Last)	18. Mather's Na	ame (First, Middle, Maiden S	n Known)
Maryland	2 should be and Mental is marked o	-C	19a. Informant's Name/Relationship (Ty	pe, Frint) W. U. 9 19b. Mailing Address (Street and Nymber or F	- 0 1/1	Town, State Zip Code)
-	1 and 2 Health em 27 i	100	20a. Method of Disposition	20b. Place of Disposition (Name of	Date 20c. Loca	ation - City or Town, State
Baltimore	Pages nent of I nnt: If it ury or o		1 Burial 2 Cremation 3 R 4 Donation 5 Other (Specify)	comptony cromatony or other place) i e i	3-17-04.	Forest Hill, MD
Balti	permit. Pag Department Importent: any injury o		21. Signature of Funeral Service Licens	2. Name anghadgress of Facility Reacety 23. Name 23. Na	natives Fune	ral + Cremation Cit.
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the death. Do not enter the mode of dying, such as cardiante cause on each line.	ac or respiratory arrest,	Approximate Interval Between
	Pnysician /Medical	r v	Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence of):	anoma	- 14R
	Examiner		Sequentially list conditions,).	Staget	
V	uted d ansit	Examiner	Sequentially list conditions, if any, reaching to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Cruel for (or all a contectment):		
90,	ate be executed hysician and the burial-transit		resulting in death) Last	Due to (or as a consequence of):		
68760	certificate be Iding physicia Ise as the bur	edical		1	227.2	
Box	death certifica e attending ph ed for use as th	by Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy	23	ld. Date of delivery Month Day Year
o.	the dea by the a ached fo	hysic	1 Yes 2 No	4☐Pregnant at time of death 5☐ Other (specify)9☐ Unknown		
s, P	w requires that the de been signed by the should be detached	by P	Part II. Other significant conditions con	ntributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use	e contribute to the cause of death?
Records,	w requi	Completed			-	24b. Were autopsy findings available prior to completion of cause of
l Re	The law ate has b page 2 sl	Somp			autopsy performed? 1 ☐ Yes 2 🖟 No	prior to completion of cause of death? 1 🗆 Yes — 2 🗆 No
Vital	Physicien: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	locaital:	eath (Check only one)	
of	S S :=	To_	1 Yes 2 No	T inpatient 2 ENOutpatient 3 DOA 4 Nursing	Home 5 Residence 6	
ion	Attending Phy r death. ector: After thi by the funeral or the fune	ation	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No		
Division	F F F	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and City or Town, State)	Number or Rural Route Number,
	2 2 0 0	2	29a. Certifier 1 Certifying Physics	sician: To the best of my knowledge, death occurred at the time, date and place ner: On the basis of examination and/or investigation, in my opinion, death occ	ce, and due to the cause(s) a curred at the time, date and p	nd manner as stated.
	a Hospital 24 hours a b Funeral D etely filled i	dic	(Check only 2 Medical Exami	and manner stated.		place, and due to the cause(s)
	To the Hospi within 24 hou To the Funel completely fil	Medical		and manner stated. 29c. License number		signed (Month, Day, Year)
	To the Hosp within 24 hou To the Funel completely fil	Medica	29b. Signature and title of certifier Veronice	and manner stated. 29c. License number		signed (Month, Day, Year)
	To the Hosp within 24 hou To the Funel Completely fill	Medica	29b. Signature and title of certifier Veron CP 30. Name and address of person who or	and manner stated. 29c. License number		

			For State Registrar		State of Ma	aryland /	Depa <i>Cei</i>	artment of hartificate of	lealth and <i>Death</i>	l Mental H	giene A	2004	08889
	Dhysisi	37 38.	1. Decedent's Name (Fig.							2. Date of D	eath Day	Year	3. Time of Death
	Physicia /Medic		KAREN	JO SHUI	LEY					March	12, 20	04	8:07A M
	Examin	er	4a. Facility Name (If not	-				4b. City, Town, o	or Location of De	ath	4c. Co	unty of Death	
	14		Greater Ba 5. Social Security Numb			Center e (In yrs. last	hirthday)	Towson If Under 1 Year	If Under 24 H	rs. 8 Date of B		timore	
v	Funeral Director	2	218-54-0187	1	☐M 2 汉 F	53	Yrs.	Months Days	Hours M	n. 8. Date of B (Month, D			olece (State or Foreign and Intry)
2			Usual Residence of Dec							11/10/	1900		
	death with the Maryland ms 23a or 28a-f show Fmust be notitied at		10a. State 10t	o. County		10c. City, To	own or Lo	cation					10d. Inside City Limits
7	e Ma	cto	MD	BALTIM	ORE	TOWS	ON						1 □ Yes 2 No
ARen	vith th	Funeral Director	10e. Street and Number					10f. Zip Code			10g. Citizer	of What Cou	ntry?
4	s 23s	rai	1581 DELLS	SWAY ROA	AD 12. Was Decedent 8	Ever in 11 S	12.1	2128		/Consider Van as N	US	A Race - Ameri	age Indian
~	after de or Item	n n	11. Marital Status 1 Never Married	2□ Married	Armed Forces?		13. 1	Was Decedent of I f Yes, specify Cub	an, Mexican, Pu	erto Rican, etc.)		Bfack, White,	
~ <u>~</u>	urs af	by	3 ☐ Widowed 4 ☐		1 ☐ Yes 2 ☐ N If Yes, Give A Year or Dates:			Yes 2√√ No	Specify:		Sp	ecity:	ITE
70	72 hou natura	Completed		Decedent's Ed		16	Sa. Dece	lent's Usual Occup	oation	ndina.	16b. Kind	of Business/In	
2/8	thin thin	npie	Elementary/Secondar	n <i>hy high</i> est gra y (0-12)	College (1-4or 5	i+)	life.	OO NOT use retire	d)	CINITY			
2/2	Hygier ther th	S	12TH GRADE				НО	MEMAKER				HOME	
ع <u>د</u>	be fill had off	Be	17. Father's Name (First CLIFTON V		2AFFD					ame (First, Middle R FRANCES			
<u>چ</u> کے	should be nd Mental markad c	²	19a. Informant's Name/			-	Ob Marlin	g Address (Street	L				. 0 . 4 .)
Show Marylan	d 2 sho th and 7 is my freum								7520	N DESCRIPTION OF			CONTRACTOR 1
	Health tem 27 other tr		MEAGAN SHUL 20a. Method of Disposit		DAUGHT	20b. Place	of Dispo	NDRUM CO		. 104 E		ion - City or To	21234 own, State
Baltimore	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is markad other than "natural", or Items 23a or 28a-1 show any injury or other treumatic event, the Medical Examinar must be notified at once.		1 ☐ Burial 2 ☐ Cr 4 ☐ Donation 5 ☐		Removal from State		-	matory or other pla MATORY,		16/2004	CATYON	SVILLE	ME
al Ei	permit. Pag Department Important: I any injury o once.		21. Signature of Funera		1	PILTITO		. Name and Addre					OME, P.A.
ä	permi Depar Impo any ir		Heath	u N.	Viegen	A STATE OF THE STA	8	521 LOCH					
	178 17		23a. Part1. Enter the di shock, or heart fai	sease, or comp	olications that caused one cause on each lin	the death. D	o not ent	er the mode of dying	ng, such as card	ac or respiratory	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Fina disease or condition	il	Myoco	edu	Q,	Hout					Onset and Death
	/Medical Examiner		resulting in death)		Du to (or as	a consequenc	e of):	20					
	· ·	_	Sequentially list condition	aris,	Nicole	iles i	ine	leh.				à,	
	led Isit	nine	Sequentially list condition if any, leading to immediate. Enter Underlying Cause (Disease or injurious Cause)	g	Due to (or as	a consequenc	20 OT):	1 /	Cula .				
	akecul al-trar	Examine	that initiated events resulting in death) Last		Due to (or as	a consequenc	e of):	- (رسمرو				
8760,	cate be executed physician and the burial-transit	dical			d.								
9		ledi		E-									
Вох	death certific attending p	an/N	IF FEMALE: 23b. Was decedent pre	griant	23c. If yes, outcome 1 Live birth		ath 3 [Ectopic pregnanc	v		23d.	Date of delive	,
	e dea the at	Physician/Me	in the past 12 mon 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	MAS!	4☐ Pregnant at 9☐ Unknown	time of death		Other (specify) _	, 			Month	Day Year
P.0	The law requires that the death certifi ate has been signed by the atlending page 2 should be detached for use as		Part If, Dther significan	t conditions of	ontributing to death by	ut not resulting	a in the ur	oderhijen cause au	on in Part I	23a Did	tobacco use	contribute to the	ne cause of death?
ds,	signe d be	d by					y o	, , , , , , , , , , , , , , , , , , ,			Yes 2 D		pably 4 □Unknown
Š	w requir been si should	ete						-		24a. Wa	2 22	4b Moso suto	nest findings available
Re	The lav	Completed								auto	ppsy ormed?	prior to co	psy findings available mpletion of cause of
ta	icien: Th	ပိ	25. Was case referred t	o medical					26 Place of D	1 ☐ Yes eath Check onl	2110	1 🗌 Yes	2 □ No
<u> </u>	d is	0 8	examiner?		Hospital: patie	nt 2 ER/o	Outpatien	t 3 DOA Ott	lor.	Home 5 Res	12.5	Other (Specif	v)
9	ding Ph h. After thi funeral	Į.	27. Manner ath		28a. Date of Injur (Month, Day	v 28b	. Time of	28c. Inju	The Control of the Co	28d. Describe			
io	oat Dr:	atic	2 ** ccident	Pending investigation			,,		Yes 2 □ No				
Division of Vital Records,	l or Attend after death Director:	Certification:	3 ☐ Suicide 6 4 ☐ Homicide	Could not be determined	28e. Place of fng building, etc	ury - At home, c. (Specify)	farm, str	eet, factory, office		28f. Location City or To	(Street and Nown, State)	umber or Rura	il Route Number,
	Hospitel of the control of the contr		20.0.4		1/1					+			
	Hos 24 ho Fun etely f	Medical	29a. Certifier 1	Medical Exam	ysician: To the best of niner: On the basis of and manner sta	examination	and/or inv	estigation, in my o	me, date and pla ppinion, death oc	ce, and due to the curred at the time	cause(s) and date and pla	d manner as si ce, and due to	tated. the cause(s)
	To the Hospitel or Atta within 24 hours after de To the Funeral Directo completely filled in by II	Me	29b. Signature and title	of certifier	,			29c. Licens	e number	I	29d. Date	gned (Month.	Day, Year)
			Tau	aut !	+ ten	2 -	-	03	5727		3/12	64	
	10		30. Name and address (of person who	completed cause of de	eath (Item 23a	a) (Type.	Print) GAWR	ence A.	Russ 40	3/		
	Sta	te <	31. Date filed for D	ay. Xear)		ar's Signature		المستراب	-1100	cja.	٠		
	Registr		MAK	1 9 2004	Bane	K	Ray	A					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 08890 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** March 16, 2004 2:50 A Joseph (nmn) Szymar 4a. Facility Name (If not institution, give street and number) Szymanik /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson Gilchrist Center 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral Ж** м 2□ F Maryland 83 Director 219-01-1009 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Bel Air Maryland Harford 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 0 21014 USA 23a 128 Fairmont Drive Funeral 14. Race - American Indian, Нетв 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 natural, or 1 ☐ Yes 2 ☐ XNo Specify: Specify: 2 White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) nd Mental Hygiene. marked other than U.S. Government Wood Model Maker 10 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) h and Mental I Catherine (nmn) Wiecorek Szymanik Luckas (nmn) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 128 Fairmont Drive, Bel Air, Maryland 21014 of Health Dolores Szymanik - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of I Important: If it any injury or o once. to 1 XBurial 2 Cremation 3 Removal from State * 4 □ Donation 5 □ Other (Specify) Bel Air Mem. Gardens 3/19/04 Bel Air, Maryland 22. Name and Address of Facility McComas Funeral Home, P.A. 21. Signature of Funeral Service >1317 Cokesbury Road, Abingdon, Maryland 21009 Approximate Interval Between Onset and Death 23a. Phil Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or he in failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Riomydsarcoma /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 2:504m Due to (or as a consequence of) burial-transit Due to (or as a consequence of) 68760. attending physician Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Day Month Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown certificate has been signed by the a rector, page 2 should be detached it م 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 Yes 2 No 3 Schably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? osedh Symanik 1 Yes 2.₩No director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence State (Specify) 1 ☐ Yes 2 No the funeral 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death.
To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature in title of certifier 29d. Date signed (Month, Day, Year) 29c. License number march 16 2004 30. Name and address of person who completed cause of death (Item 23a) (Type/Rrint) Baltmore MD 2204 MORIOS 600 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar MAR 1 9 DHMH 17 Rev 1/2001

ORIGINAL

	T = For State Registrar	State of Maryland	i / Department of He Certificate of D		/giene Reg. No. 2 0 0 L	08891
Physician	1. Decedent's Name (First, Middle, L Bernard Fletche			2. Date of D Month	, Day Year,	3. Time of Death
/Medical Examiner	4a. Fecility Name (If not institution, gi	ve street and number)	a 4b. City, Town, or L		4c. County of Deel	
		Sex 7. Age (In yrs. la		If Under 24 Hrs. 8. Date of B	BO-1+1	mor L hplace (State or Foreign
Funeral Director	213-20-8180		77 Yrs. Months Days	Hours Min. (Month, E Oct 5	irth 9. Bin Day, Year) Co , 1926 Ma	ryland
/land	Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Location			10d. Inside City Limits
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with the sa or 2	10e. Street and Number 4517 Powell Ave	75	10f. Zip Code 21206		10g. Citizen of What Co United Sta	
of the state of th	11. Marital Status	12. Was Decedent Ever in U.S	i. 13. Was Decedent of His If Yes, specify Cuban	panic Origin? (Specify Yes or N., Mexican, Puerto Rican, etc.)	14. Race - Ame Black, Whit	
5-0036 72 hours after natural; or the standard search et and et a	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 AYes 2 No If Yes, Give Year or Dates: 44-46	1 ☐ Yes 2 ☑ No	Specify:	Specify: Whi	.te
21215-0036 ed within 72 hours at Sylene. Sylene. Sylene. Sylene. Sylene. Sylene. Sylene. Sylene. Completed by I	15. Decedent's (Specify only highest g	Education rade completed)	16a. Decedent's Usual Occupat (Give kind of work done du life. DO NOT use retired)	ion iring most of working	16b. Kind of Business Baltimore	
21214 swithin liene.	Elementary/Secondary (0-12)	College (1-4or 5+)	Police Officer		Barcimore	
	17. Father's Name (First, Middle, Las	r Sullivan, Sr.	1	18. Mother's Name (First, Middle Ethel Thomas	le, Maiden Sumame)	
Maryland Maryland M2 should be fill thand Mental th to 1s marked out treumatic even	19a. Informant's Name/Relationship		19b. Mailing Address (Street an		ber, City or Town, State, .	Zip Code)
ore, Mass and 2.1 strand 2.1 stra	Peggy L. Sulliv		A CONTRACTOR OF THE PARTY OF TH	ve., Baltimore,		Town Code
more Pages 1 Pages 1 Pages 1 Pages 1 Pages 1 Pages 1 Pages 1	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Special Control of the Control	☐Removal from State ce	ace of Disposition (Name of imetery, crematory or other place, esapeake Cremat	l Har 19	20c. Location - City or Beltsville	
Sull Dealtimore permit. Pages 1: Inportent: If item any injury or oth once.	21. Signature of Funeral Service Lic		22 Name and Address	The state of the s		7 110
w sere	23a. Part 1. Enter the disease, or co		8/1/ Gree	n Pastures Dri	ve Baltimor	ce, MD Approximate
Physician	shock, or heart failure. List on Immediate Cause (Final disease or condition	y one cause on each line. HYPPA+ OAS	, on	,		Interval Between Onset and Death
/Medical Examiner	resulting in death)	Due to (or as a consequ	ence of):			
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Box 68' leath certificat attending phy I for use as th	IF FEMALE:	23c. If yes, outcome of pregnar	204		204 Days of day	·
of Vital Records, P.O. Box 68 Physician: The law requires that the death certifica r this certificate has been signed by the attending phy ral director, page 2 should be detached for use as the	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Fetel 4 ☐ Pregnant at time of de	death 3 Ectopic pregnancy		23d. Date of de Month	Day Year
P.O. that the de ed by the detached	9 Unknown Part II. Other significant conditions	9 Unknown	liting in the underlying cause gives	n in Part I 23e Dir	I tobacco use contribute to	o the cause of death?
dS, Fuires that is signed ald be de	Partii. Ottiai significant conditions	commoding to death but not resu	ining in the underlying cause given	_	A	robably 4 \(Unknown
Vital Records, sicien: The law requires to entiticate has been signer irector, page 2 should be	**			24a. We	opsy prior to	utopsy findings available completion of cause of
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of Vital hysician: hysician: nis certification. I director.	l examiner? ∴ *** 1 □ Yes 2 Ø No	Hospital: 1 ☐ Inpatient 201	ER/Outpatient 3☐ DOA Other	26. Place of Death (Check only 4 □ Nursing Home 5 □ Re		ocify)
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he Hosp in 24 hou he Fune pletely fil	(Check only 2 Medical Ex	aminer: On the basis of examinat and manner stated.	ion and/or investigation, in my op	inion, death occurred at the time	e, date and place, and du	to the cause(s)
To the within To the complex complex to the complex	29b. Signature and title of certifier	PL	29c. License	number	29d. Date signed (Mon	n, Day, Year)
(X)	30. Name and address of person wh	no completed cause of death (Item	23a) (Type, Print)	1100	NION Ch	17,2001
5	Dr. Michael Pip	Kin 9000 F (an) 32. Registrar's Signal	Klin Squar	e Drive Bo	Itimore	MD, 21237
State Registra	**** 4 0 0004	Resta A	ALCOHO!			

Summerhill Frany

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760,

	•	1 - State Registrar AMEND ITEM #26			Health and Mental I Death	Reg. No	2006	08892
nysicia	,	Decedent's Name (First, Middle, Last)		4 .	2. Date of Month		y Year	3. Time of Death
Medica	al .	4a. Facility Name (If not institution, give s	SUMMERH		r Location of Death	2 4	QUOT	1 06 56 M
mine	er	North Arunde	1 Hospital	Glen 6	UCNIO	A	nne A	cundel
I		5. Social Security Number 6. Sex		irthday) If Under 1 Year Months Days	If Under 24 Hrs. 8. Date of Month	f Birth Day, Year)	9. Birti	hplace (State or Foreign untry)
		Usual Residence of Decedent	7 62	Yrs.	05/	23/14	11 111	egina
		10a. State 10b. County	10c. City, To	wn or Location				10d. Inside City Limits
•	Funeral Director	Mary In Anna Aru	rpc/ So	CU ENN 10f. Zip Code		10a Cit	izen of What Co	1 Yes 2 No
	5	1856 Hank 1	Delle	3-11	44	log. Oil	USA	unity
ınera		7 7 7 7 7	2. Was Decedent Ever in U.S. Armed Forces?		Hispanic Origin? (Specify Yes o an, Mexican, Puerto Rican, etc	r No-	14. Race - Ame Black, White	
	by Fr	1 Never Married > Married 3 Widowed 4 Divorced	1	1□Yes 2⊒No	Specify:		Specify:	1
6	tea	15. Decedent's Educ (Specify only highest grade	eation 16	a. Decedent's Usual Occup	pation	16b. K	ind of Business/	Industry
-	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work done life. DO NOT use retire	d)		Don C	Par E.
-	200	17. Father's Name (First, Middle, Last)		LABOVER	18. Mother's Name (First, Mi	ddle, Maiden	Sumame)	
	To Be	HArvey DAVE	/		Helen PAR	HErson	~	
		19a. Informant's N me/Relationship (Typ			and Number or Rural Route N			
		20a. Method of Disposition	20b. Place	1856 WA W/C	Date of	Saffering Commencer	ocation - City or	
		1 Burial 2 □ Cremation 3 □ Ro 4 □ Donation 5 □ Other (Specify)	emoval from State	ery, crematory or other pla CRN BAN'S F (Chro Conclus	104	/ / .	11
	-	21. Signature of Funeral Service Lio	6	22. Name and Addre	ess of Facility CWATE	m-1	me 1 2	in collere
		Sluy Ho	crix		Torstown Id		MORE,	21215
		23a. Part 1 Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.	not enter the mode of dyli	ng, such as cardiac or respirate	ry arrest,		Approximate Interval Between Onset and Death
		disease or condition resulting in death)	Due to (or as a consequence	∍ of):				M. Wes
		Sequentially list conditions, b						
	aminer	Cause (Disease or injury	Due to (or as a cons. quen.	r Mr				
	ŭ	that initiated events cresulting in death) Last	Due to (or as a consequence	→ of):				
	by Physician/Medical	d						
4	/We	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnancy	_			23d. Date of deli	very
7	200	in the past 12 months?	1 Live birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown	h 3 Ectopic pregnanc 5 Other (specify)	y		Month	Day Year
	Phy	9 Unknown Part II. Other significant conditions con		in the underlying cause an	von in Port I 23a I	Oid tobacco i	rea contributo to	the cause of death?
	d by	I have the lester		in the underlying cause giv				babiy 4 Unknown
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	3	GE 144		Ott	26. Place of Death (Check o	100		
	ge	25. Was case referred to medical examiner?			er: 4 Nursing Home 5	tesidence		ify)
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DHMH 17 Rev 1/2001

	11.11.	D ITEMS 23A,25,27		,	Certificate of	f Death		Reg. No.	04	06833
Physic	ian	Decedent's Name (First, Middle, Decede			CCHOOL NEC		2. Date of Dea Month	Day,	Yeer	3. Time of Death
/Med Exami		JEN 4a. Facility Name (If not institution,	INIE	per)	SCHOOLNIC		r Locetion of Death	. 1 0	2004 y of Death	6:00PT
Exam	rier	ROLAND PARK P	-	/		BALTIM			•	N/A
Funeral Director		280-20-6296	6. Sex 7. 1 □ M 2 □ F	Age (In yrs. last birth	Months Day			, 1912		ace (State or Foreign try) OH
and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location		<u> </u>	_	10	Od. Inside City Limits
e-f sh	ş	MD N/A		ВА	LTIMORE					1 ☐ Yes 2 ☐ No
72 hours after death with the Maryland neturel; or items 23a or 28e-f show Iteal Examinat must be notified at	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of		•
s 23a	Funeral	830 W. 40TH ST	REET #854	ont Ever in U.S.	12 Man Decedent of	21211	1016-WN-	14.5-		U.S.A.
ei', or items Examinat m	Š	11. Marital Status 1 □ Never Married 2 □ Marrie 3 □ Widowed 4 □ Divorced	Armed Force	es? X) No	13. Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 ☑ No		rto Rican, etc.)	Specif	ce - America ck, White, e fy:	
Hygiene. ther than "neturei', int, the Medical Ex	eted	15. Decedent's (Specify only highest	Education grade completed)	16a. D	ecedent's Usual Occu Give kind of work done ife. DO NOT use retin	upation e during most of w	orkina	16b. Kind of B	Business/Ind	ustry
/giene. er than t, the Ma	Completed	Elementary/Secondary (0-12)	College (1-4	Or 5+)	ife. DO NOT use retir EMAKER	ed)		OWN HO	ME	
f Heelth and Mental Hygiene. Item 27 is marked other than "neturei", other traumatic event, the Madical Exa	To Be	17. Father's Name (First, Middle, La HARRY	ast)	RO	SSIN	18. Mother's Na	ame (First, Middle,	Maiden Surnar		NOWN)
is me		19a. Informant's Name/Relationshi			Mailing Address (Stree					Code)
t of Heelth If item 27 or other tr		SANDRA K. DALSHE	.1MER / DA		ROLAND ME	WS - BAL	TIMORE, I			01-1-
		1 ☐ Burial 2 🂢 Cremation 3 4 ☐ Donation, 5 ☐ Other (Spe	B □Removal from St	ate cemetery,	crematory or other plants		3/17/04	20c. Location	•	
Department of Important: If any Injury or once.		21. Signatura 1 Juneral Service Li	n 111	HILLIO	22. Name and Addr				NSON, ROS	
lmpo any i	1	X/////sliver	Bruse	n	8900 REIS					
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e etter	iciar	Part II. Other aignificant conditions	s contributing to death	h but not resulting in th	a underlying cause of		1	obaaaa uga aa	ndribute to t	the serves of death?
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erthis neral di		27. Manner of Death	28a. Date of I	atient 2 ER/Outpe	e of 28c. Inju		Home 5 TReside			
or: After the fune	atio	1 Swatural 5 Pending investigat	tion FEB. 2	Day Year) Inju 5,2004 UNK		Yes 2 No	SUBJECT	FELL		
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24 hour	Medicai	29a. Certifier 1 Certifying 1 cone)	Physician: To the be- aminer: On the basis and manner	st of my knowledge, do of examination and/o	eath occurred at the ti r investigation, in my	me, date and place opinion, death occu	and due to the ca	ause(s) and ma	nner as stat	red
within To the	Me	29b. Signature and title of certifier			29c. Licens			9d. Date signed		
		> M Labele	'e Mac G	reger o	70 013	3657	The	harch	15.2	004
									. 0 / //	
6		30. Name and address of person wh	o completed cause of REGOR	f death (Item 23a) (Ty	70 013 pe, Print) +0457	REET, BA	LITIMOR	D) 170 .	2121	1

DHMH 16 Rev 6/95

			For State Registrar	State of Ma	aryland	l / Depa <i>Cei</i>	artment of H tificate of L	ealth ai Death		Re	g. No.	004	000	
	Physicia	an	Decedent's Name (First, Middle, Last) Theres	a Taylor	r					Date of Death Month	Day	Year	3. Time of Dea	ath M
	/Medic	al	4a. Facility Name (If not institution, give s				4b. City, Town, or	Location of		arch	17, 4c. Coun	2004 ty of Death	3:59P	
	Examin	er	Greater Baltimore		Cente	r	Towson				Balt	imore		
(a)	Funeral Director		5. Social Security Number 6. Sex 215-56-6383		e (In yrs. la 55		If Under 1 Year Months Days	If Under 24 Hours		Date of Birth (Month, Day, lay 3,	1948	9. Birthp Cour Mary	place (State or Fo ntry) Land	reign
	land bw		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Lo	cation					1	0d. Inside City Li	imits
	Mary I she	tor	MD Baltimor	е	Owing	gs Mil	.1s						1 Tyes 2	No
	th the)irec	10e. Street and Number				10f. Zip Code			10	g. Citizen o	f What Cour	ntry?	
	ath w	ral	412 Academy Avenue		C 11 C	10		1117	ing (Connet	. Van ar Na	USA	ace - Americ	an Indian	
136	be filed within 72 hours after death with the Maryland ital Hyglene. d other than "natural", or items 23a or 28a-1 show event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 ▼ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:			Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2X No	Specify:	Puerto Rica	an, etc.)	ВІ	ack, White,	etc.	
ş	72 hou	ted	15. Decedent's Educ (Specify only highest grade	cation		16a. Dece	dent's Usual Occupa	ation during most i	of working	1	6b. Kind of	Business/In	dustry	
21215-0036	within 72 ene. than "nal	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	life.	DO NOT use retired	()	-,g	9	Own 1	Home		
	filed w Hygier ther th	Col	1.2 17. Father's Name (First, Middle, Last)			нос	se Wife	18. Mother	's Name (F	irst, Middle, N				
Baltimore, Maryland		To Be	Sterling Cooper	0.111		AGE MARIN	ng Address (Street	Emi1	y Hal	.1			Cadal	-
a S	10		19a. Informant's Name/Relationship (Ty.) Janet Higgs - Daug				Averill							
ē,	s 1 and if Health itsm 27 other tr	- 3	20a. Method of Disposition		20b. Pla	ace of Dispo metery, crei	sition (Name of matory or other plac	e)	Date) 2	20c. Location	n - City or To	own, State	
Ë	Pages nent of ant: If it ury or o		1 ☐ Burial 2 ☑ Cremation 3 ☐ R `4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		view (Crematory	3	3-19-2				Maryland	
Balti	permit. Pages Department of Important: If it any injury or once.		21. Signature of Funeral Service License	- III	De	70	2. Name and Address 00 S. Bee	chfiel	ld Ave	nue; B	altim			
	Physician		23a. Part1. Enter the rise, se, or complishock, or heart railure. List only or Immediate Cause (Findisease or condition	./1	d the death. ne.	-	er the mode of dyin		ardiac or re	espiratory arre	est,		Approximate Interval Betwee Onset and Deat	
1	/Medical Examiner		resulting in death)	Due to (or as	a consequ	ence of):	YONIA						1 wee	k
1		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequ	ence of):			500				4 4 1 4	
	ate be executed nysician and he burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	TAL a consequ		VCEX M	ETAI	777				< 14/	?
8760,	ate be chysician	cal	C.	ı										
P.O. Box 6	that the death certificat ed by the attending phy detached for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome 1 ☐ Live birth	2 Fetal	death 3	Ectopic pregnancy			04.4		Date of deliver	ery Day Year	r
0	he de	yslc	1 ☐ Yes 2 ØNo 9 ☐ Unknown	4□ Pregnant a 9□ Unknown	t time of de	ath 5L	Other (specify)							
	uires that t signed by d be detac		Part II. Other significant conditions con	ntributing to death b	out not resu	lting in the u	nderlying cause giv	en in Part I.		23e. Did tob	~/		he cause of death	
Vital Records,	Physician: The law requires that the death certifica ribs certificate has been signed by the attending phral director, page 2 should be detached for use as t	Completed								24a. Was ar autops perform	y ned?	prior to co death?	ppsy findings avai	itable e of
tal	iclan: Th certificate ector, pag	Be Cc	25. Was case referred to medical					26. Place	of Death (C	1 ☐ Yes 2		1 🗆 Yes	2□ No	
Ž	nysich nis cer direct	To B	examiner?	fospital: 1 Inpati	ent 2 🗆 6	R/Outpatie	nt 3 DOA	er: 4 🗆 Nur	sing Home	5 🗆 Reside	nce 6 □C	ther (Specia	(y)	
Division of	ding Alte		27. Manner of Death Natural 5 Pending Decident investigation	28a. Mate of Inju (Month, Da	ury ay Year)	28b. Time o Injury	Wor	yat k? Yes 2 ☐ N		I. Describe ho	w injury occ	urred		
Divis	afte Dir	Certification:	3 Suicide 6 Could not be 4 Homicide determined		jury - At hor tc. (Specify		reet, factory, office		28f.	Location (Sti City or Town		nber or Run	al Route Number,	,
	To the Hospital or Attanowithin 24 hours after death To the Funeral Director:	edical (29a. Certifier (Check only one) (Check only one) (Check only one)		of examinat									
	To the To the Comp	ž	29b. Signature and title of certifier				29c. Licens		3		9d. Date sign		* '	/
			171000				100		30		1191	17	2004	
	/		30. Name and address of person who co	6569 A	1. CM	An (6)	Print)	47,4	CRE	MO	2/2	04		
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) MAR 1 9 2004	2. Regist	rars Signat	ure	de							

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1 1 1 1 1	Physici /Medi Examir	cal	Decedent's Name (First, Middle, Last, Sephine A. Facility Name (If not institution, give	G To	ome	4b. City, Town, or	Location of Deat	2. Date of De Month Marc	ath Day		3. Time of Death
	Funeral Director	4.1	5. Social Security Number 6. Sec	1. 001	TEP s. last birthday) Yrs.	If Under 1 Year Months Days	if Under 24 Hrs Hours Min.	8. Date of Bird (Month, Da	y, Year)	C	thplace (State or Foreign cuntry)
	the Maryland 28a-f show	Director	10a. State 10b. County MD Baltir 10e. Street and Number		lity, Town or Lo	Baltime	ore High		10a Citize	en of What Co	10d. Inside City Limits 1 Tyes 27 No
	2 should be filed within 72 hours after death with the Maryland and Mental Hygene. is marked other than "natural", or items 23a or 28a-f show fematic avent. It a Medical Exert are fund for indifficial	Funeral Dir	2918 Vermont Avenu	12. Was Decedent Ever in I	U.S. 13.	10f. Zip Code 2 Was Decedent of Hi f Yes, specify Cuba	1227 ispanic Origin? (S n, Mexican, Puen		Uni	Lted St Race - Ame Black, Whit	tates
15-0036	72 hours aft "natural", or edical Exerc	leted by F	1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Edu (Specify only highest grade	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: cation e completed)	16a. Dece	1 ☐ Yes 2 ☒ No dent's Usual Occupa	ation during most of wo	rking		Specify: V	White
Maryland 21215-0036	e da Be	Be Completed	Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last)	College (1-4or 5+)		DO NOT use retired	Ker 18. Mother's Nar	ne (First, Middle,	Maiden S	итате)	stillery
2	1 and 2 should Health and Mer (em 27 is marke other treumatic	J.	Harry 19a. Informant's Name/Relationship (Ty. Jerry Toomey - Sor	1	2916	ng Address (Street a	Ave., Bai	ıral Route Numbe		Town, State, 2	Zip Code)
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 is marke any injury or other treumatic. Once.	(20a. Method of Disposition 1 Burial 2 Cremation 3 R 4 Conation 5 Other (Specify) 21. Signature of Funeral Service Identity	Lo	udon Pa	sition (Name of natory or other place rk Cemete . Name and Addres	ery 3-22 s of FaciliAmbi	cose Fun	Balti eral	more, Home o	MD f Lansdowne
- Mg	Physician /Medical Examiner		23a. Per11. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the deale cause on each line. Advanc Due to (or as a conse	ed L	9 Hammond of dying the mode of dying (is Ferry g, such as cardiac Can Ce	Rd., Lar	nsdow rest,	ne, MD	Approximate Interval Between Onset and Death Six Years
8760,	certificate be executed utility physician and use as the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to for as a consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) consecutive to (or a) co		illatio	7				20 days
O. Box 6	death e atter	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of pregn 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of a 9 □ Unknown	aldeath 3 □	Ectopic pregnancy Other (specify)			236	d. Date of del	ivery Day Year
ords, P	w requires that the been signed by th should be detache	by	Part II. Other significant conditions con	tributing to death but not re	sulting in the ur	nderlying cause give	n in Part I.		bacco use		the cause of death?
Vital Hecord	The lar ate has page 2	e Completed	25. Was case referred to medical				26 Place of Dea	24a. Was a autop: perfor 1 Yes	sy med? 2 No	24b. Were au prior to death? 1 \(\text{Yes}	topsy findings available completion of cause of
ō	ding Phy I. After this funeral d	atlon: To B	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	ospital: 1 Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Injury Work	r: 4 🗆 Nursing H	ome 5 Resid	ence 6		city)
DIVISION	z e i e	Il Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	fy)			City or Tow	n, State)		ral Route Number,
	To the Hospitel of within 24 hours af To the Funerel D completely filled in	Medical	(Check only one) 2 Medical Examin (Check only one)	ician: To the best of my knier: On the basis of examina and manner stated.	ation and/or inv	estigation, in my op	number	rred at the time, d	ate and pl	ace, and due	to the cause(s)
	B		30. Name and address of person who con Omid Chala	mpleted cause of death (Item	m 23a) (Type, F						7,2004 ,MD21225
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature						

DHMH 17 Rev 1/2001

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			Please						All Copies	•	∂.			
			State of Maryland / Department of Health and Mental Hygiene Certificate of Death)40	8898		
	W.	2.	Decedent's Name (First, Middle, Last)						2. Date of Death 3. Time of Death					
	Physicia		JAMES WALLACE TRAMMELL						Month Day Year March 14. 2004 5:50P					
	/Medic Examin		4a. Fecility Name (If not institution, g				4b. City, Town,	or Location of Deat		4c. County of E				
and out			HOSPICE OF BALTII	MORE:GIL	CHRIST	CENTER				Baltimo	ore Cou	ıntv		
25	Funeral		Social Security Number 6.	Sex 1₩ 2□F	7. Age (In yrs.		If Under 1 Year Months Days		B. Date of Birth (Month, Day,	Year) 9.	Birthplace (St Country)	tete or Foreign		
	Director		247-18-0516 Usual Residence of Decedent	X	83	Yrs.			Oct 20,	1920 s	outh G	arolina		
7	ehow		10a. State 10b. County		10c. Cit	y, Town or Lo	ocation				10d. Insi	de City Limits		
Zooy	Mary Fied	tor	Maryland Baltime	oro Coun	t 57	Tows	on				1 🗆	Yes 2X No		
ر	or 28a-f	irec	10e. Street and Number 10f. Zip Code 21.286							0g. Citizen of Wha	t Country?			
_	th wit	by Funeral Director								USA				
YC	ltama 23a	ner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Y							y Yes or No- an, etc.) 14. Race - American Indian, Black, White, etc.				
March 36	or II	y F	1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	lf-Yes, Gir	² □No W	J2	1 ☐ Yes 2 🏋 No	Specify:		Specify:	White			
James m	72 hours after death with the Maryland "netural", or Itama 23a or 28a-f ehow idical Ezar a er must be rediffed at	ed b	15. Decedent's	Year or D	ales:	16a Dece	dent's Usual Occu	pation	1	16b. Kind of Busine				
15	n n	Completed	(Specify only highest g	rade completed) College (1.4045.)	(Give	kind of work done DO NOT use retire	during most of wo	rking		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
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James	be filed ntal Hygi of other event, I	Be	17. Father's Name (First, Middle, La.					18. Mother's Nar	me (First, Middle, M	Maiden Surname)				
Na P	should be nd Mental s marked o umatic eve	10	A. B. Robertson Eva						Trammel1					
 - an	sh and sh		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailii	ng Address (Stree	t and Number or Ru	ural Route Number,	City or Town, Stat	e, Zip Code)			
i, e	1 and 2 Health em 27 ithar tra		Mrs. Juanita Nor	ris Tra		606	Yacmouth sition (Name of	Road, To	wson, Mar	yland 21	286			
S S	ges 1 au of of Hea if item or otha		20a. Method of Disposition 1 ☐ Burial 2 XCremation 3	☐Removal from	State	cemetery, crei	matory or other pla			2fc. Location - City				
Camme	permit. Page Department of Important: If eny injury or once.		4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice	1	Gre		unt Cemei	tery 3/18	8/2004 <u>I</u>	Baltimore	, Mary	land		
Ba	permit. Depart Import Import eny in		Martin	Lau	w		Mitchell.	-Wiedefel	d Funeral	Home, I	nc.			
	GLESS!		Martin D. La 23a Parti. Enter the disease, or co	mplications that of	aused the deat	h. Do not en	500 Yorl	Read, P	altimore, correspiratory arre	Marylan	2 2			
	Physician		shock, or heart failure. List on Immediate Cause (Final	ty one cause on e			~~~	CA			Onset a	Between and Death		
	/Medical		disease or condition resulting in death)	a. Due to	(or as a conseq		incom				geo	45		
11.1	Examiner													
1 1/1/2	P ∺	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a consequence of):									
60	and I-transil	хаш	that initiated events resulting in death) Last	c. Due to	or as a conseq	uence of):								
,09,	s be executed sician and burial-transit	aiE			(
687	ficate physis the			d										
Xo	DOO OF STORY									23d. Date of	23d. Date of delivery			
	Sport of the past 12 months? 1 Yes 2 No 9 O'Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Live birth 2 Fetal death 5 Other (specify) 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 1 Live birth 2 Fetal death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco us 1 Yes 2 24a. Was an								Month	Month Day Year				
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360	has l	mpi							24a. Was ar autopsy perform	/ prior	autopsy findi to completion h?	of cause of		
<u></u>	n: Th ficate or, pa	e Co	25. Was case referred to medical	1				00 Di	1 Yes 2	10 1 0 1	Yes 2□No			
Ş	ysician: The lis certificate hadrector, page	To Be	examiner?	Hospital:	Inpatient 2	ER/Outpatier	nt 3 DOA Ot	har	ath (Check only one dome 5 - Reside		Specify No	Spice		
Jo C	g Phy ter thi	n: T	27. Manner of Death	28a. Date		28b. Time o Injury			28d. Describe ho		200.97 1 (0)	3/19		
ior	endin sath. or: Aft	atio	1 Natural 5 Pending 2 Accident investigat	on	, 23, 132,	,		Yes 2 □No						
Division of Vital Records,	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not determine	d 286. Place	of Injury - At hing, etc. (Specif		eet, factory, office		28f. Location (Str City or Town	eet and Number or State)	Rural Route	Number,		
Q	pital o	Ce												
The standard of the standard o											It the time, date and place, and due to the cause(s)			
											onth, Dey, Year)			
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	1		30. Name and address of person wh	1	0 1	n 23a) (Type,	Print)	(Ci Re	41	MOS	nas		
	10		31. Date filed (Month, Day, Year)	20 63 V	legistrar's Signa	Det lura	17. (Merks	DT 120	117 morce				
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State of Maryland / Department of Health and Mental Hygiene >008897 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death MARCH 17, 2004 **Physician** 02:30 A M MARY CATHERINE VOELKER BROWN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner GREATER BALTIMORE MEDICAL CENTER TOWSON If Under 1 Year BALTIMORE If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number Birthplace (State or Foreign Country) **Funeral** Days Min. Months 1 □ M 212 F Hours Director 215-44-8775 93 Jan 10 1911 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or Itams 23a or 28a-f shov other traumatic event, the Modical Exeminar must be notified at 1 ☐ Yes 2 ☑ No Directo Parkville Maryland Baltimore County 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 8800 Walther Blvd 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes. Give Λ 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-tf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No If Yes, Give X Year or Dates: Specify: Specify. White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within in the and Mental Hygiene.

7 is markad other than "r Elementary/Secondary (0-12) College (1-4or 5+) IRS Clerk Civil Service 1 yrs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ George Nicholas Voelker <u>Theresa M. Mueller</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any injury or othar traun 3 Randell Avenue, Perry Hall, 21128-9556 Norbert J. Luken, P.R. Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ₽ Burial 2 □ Cremation 3 □ Removal from State ¹ 4
☐Donation 5 ☐ Other (Specify) Dulaney Valley Mem Grdns 3/19/2004 Timonium, Maryland 21. Signa Marin aral Cold 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximately 1. Indication of the disease of the disease of the death of the mode of dying, such as cardiac or respiratory arrest,

Approximately 2. Indication of the disease of the death of the mode of dying, such as cardiac or respiratory arrest, Martin D. Lawson Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical as a consequence of): Examiner umonic organization of the control of the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last e to (or as a consequence of): and Due to (or as a consequence of): the attending physician Box 68760 Physician/Medical as the IF FEMALE esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy detached for in the past 12 months?
1 Yes 2 No Month Year Day 4 Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown ignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by æ QU 200No 1 Yes 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐No 24a. Was an 1 🗆 Yes of Vital Be 25. Was case referred to medical examiner? 26. Place of Death Check onl. one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ٥ 1 🗌 Yes 2 npatient 2 ER/Outpatient 3 DOA 27. Manner of Death ate of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Division Hospital or Attending 1 Natural Injury 5 Pending death. 1 ☐ Yes 2 ☐ No 4 hours after death Funeral Diractor: / investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a To the Funeral E Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the 29b. Signa License number 29d. Date signed (Mont., Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

)4- RJ	01814		for State		S	tate of M	Maryla					and M	lental Hy	giene		
			Registrar 1. Decedent's Name	a /First Middle	(act)			Ce	ertificat	e or L	Jeatn		2. Date of De	Reg. No. 2	104	18898
	Physici	an	•					_						12, Day 200	Year	1235 P. M
2.00	/Media		Da v 4a. Fecility Name (I			WAL et and numbe			4b City	Town or	Location of	of Death	HOLCH		y of Death	1233 F
	Examir	er	4213 Re				,,,				imore) DOG(()		10.004	//A	
	Funeral		5. Social Security N		. Sex	7.	Age (In yr.	s. last birthday) If Under	1 Year	If Under		8. Date of Birt	th	9. Birthp	place (State or Foreign
	Director		219 - 98 - Usual Residence of		1 X M	2 🗆 F	2	Yrs.	Months	Days	Hours	Min.	July Da	y, Year) 1,1982	Cour	ryland
	ow		10a. State	10b. County			10c. (City, Town or L	ocation			-			1	0d. Inside City Limits
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	1 the	rec	10e. Street and Nur						10f. Zip					10g. Citizen of	What Cour	ntry?
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	deat	ner	11. Marital Status	0,00	12.	Was Deceder Armed Force	nt Ever in	U.S. 13.				gin? (Spe	ecify Yes or No Rican, etc.)		ce - Americ	
9	after or ite	3	1 Never Marri	ied 2 Marrie	d	1 ☐ Yes 2 If Yes, Give	No		1 ☐ Yes		n, mexican Specify:	i, Puerto	HICAN, etc.)		ick, White,	etc.
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Maryland	2 should t and Ment ie marked aumatic e	ဥ	19a. Informant's Na				31 ,	19b Mail	ing Address	(Street a	nd Numbe	Y CO	_ Bea	or, City or Town	State Zin	Code
Z	s 1 and 2 should be filed within 72 hours after death with the Marylar of Heatth and Mental hygiene. Item 27 is marked other then "naturel", or items 23a or 28a-1 show other traumatic event, the Medical Examiner must be notified at		Myra H	•			مسرده									21206
ē,	Heal Hem Item other		20a. Method of Disp	position	•		20b.	Place of Disp cemetery, cre	osition (Nan	ne of			ate	20c. Location	- City or To	wn, State
SE	Pages ent of nt: f i		1 Burial 2	☐Cremation 3 5 ☐ Other (Spe	□Remo	oval from Stat	ler .					1	17 04	Baltu	M (1) (a	MAD
Baltimore	permit. Page Department o Important: If eny injury or once.		21. Signature of Fu					2	2. Name an	d A dres	s of Facility	y	11,04	134110	14) WOD
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	· · · · · · · · · · · · · · · · · · ·		23a. Pert1. Enter the	The second secon	mplication	ons th Caus	ed the dea	ath. Do not en	ter the mod	e of dying	, such as	cardiac o	r respiratory ar	rest,	1	Approximate
	Physician		Immediate Cause ((Final	ily one c	au30 011 6401	Mul	tool.	**/1	l. aL	1 . 1		de			Interval Between Onset and Death
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8760,	ate be executed hysician and the burial-transit	<u> </u>	rosening in seattly t	-231		Due to (or a	is a conse	iquence of):								
87	physi the b	dlcal		•	d											
9 X	death certifica attending ph for use as th	/Me	IF FEMALE:		230	If yes, outcom	ne of predi	nanov								
Вох	atten for u	ian	23b. Was decedent in the past 12	months?		1☐Live birth 4☐Pregnant	2 Fe	tal death 3[□Ectopic pro						ite of delive. onth	ry Day Year
oʻ.	that the di ed by the detached	Physician/Me	1 □ Yes 2 □ 9 □ Unknown	No		9□ Unknown		Geath 5	Other (spe	эспу)						
صّ			Part II. Other signif	icant conditions	s contribe	uting to death	but not re	sulting in the u	inderlying ca	use give	n in Part I.		23e. Did to	bacco use con	tribute to the	e cause of death?
Records,	n sign	d by											1 🗆 Y	es 2 No	3 Proba	ably 4 Unknown
00	aw requir as been si 2 should	Completed											24a. Was a	n 24b	Were auton	esy findings available
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Jo C	ig Ph ter th neral		27. Manner of Death		2	8a. Date of In	jury Jav Year)	28b. Time o		3c. Injury Work				ow injury occur	red	,
ō	Attending or death.	atic	1 ☐Natural 2 ☐ Accident	5 ☐ Pending investigat			-04	linkna			es 200/N	lo	Subj	ent wa	d Sho	oT .
Division	il or Attending Phater death. Director: After this in by the funeral	Certification;	3 ☐ Suicide 4 🌠 Homicide	6 Could not determine		8e. Place of I	njury - At l etc. <i>(Spec</i>	nome, farm, st	reet, factory,	office		2	8f. Location (S City or Town	treet and Numb		Route Number,
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	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	Med	-			and manner :	stated.									
	7 × 6		29b. Signature and	in the continer	1	mid				C.M.			2	9d. Date signe! March		
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	4		30. Name and addre			ered cause of	death (Ite	m 23a) (Type,	Print) 13	ll Pe	enn S	tree	t, Balt	imore,	Maryl	and 21201
	Sta	e	31. Date filed ?		10 *	3. Regis	trar's Sign	ature								
2%	Domina	30	mt i-	11 L T /11	1114	17.79		W 14	Sid.							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Yeer **Physician** Warnock March 2004 p /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 541 2nd Street Gambrills Anne Arundel If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 20XF 503-18-8820 82 Jan. 11,1922 Director South Dakota Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show nit. Pages I and 2 should be filed within 72 hours after death with the Maryla artment of Health and Mental Hygiene. ortent: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show injury or other traumatic event, the Medical Examinar must be notified at 1 Yes ZNO Anne Arundel Gambrills Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 541 2nd Street 21054 USA Completed by Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Food Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Lee Robley Elsie Taplin ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1726 Northwest #44 Lawton, Oklahoma 73505 Karen L. Parsons (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. 4 □ Donation 5 □ Other (Specify) 3/16/2004 Arlington Nat. Cem. Arlington, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home P.A. 12 Ridgely Avenue, Annapolis, MD 21401 23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoc or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Im ediaty Cause (Final di lease y condition resulting in death) Pnysician OVAMANO CARCINOMA /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760. attending physician IF FEMALE: 23c. If yes, outcome of pregnancy
1☐Live birth 2☐Fetal death
4☐Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) been signed by the a should be detached 1 Yes TO No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 No certificate 2PTNo 1 Yes To the Hospital or Attanding Physicien: within 24 hours after death.

To the Funerel Diractor: After this certific completely filled in by the funeral director, Certification: To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 182 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) who completed cause of der h (Item 23a) (Type, Print) J4 BUML VP-72/1 12Alfent Ave 32. Registrar's Signature State Registrar

For AMEND ITEM #2 PER PHY G830 4/07/04 Health and Mental Hygiene Registrar AMEND ITEM #25 PER FH G829 3/19/04 Gartificate of Death Reg. No. 2004 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 1:40 a. Dolly Ann Walton March 14 2004 /Medical pm. 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Genesis Elder Care Heritage Dundalk Baltimore If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2000 Director 219-26-8001 95 9, 1908 Virginia Sept. Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral, or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Baltimore Edgemere 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2817 Ross Avenue 21219 United States deeth 1 Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Peges 1 and 2 should be filed within 72 hours after onent of Health and Mentat Hygiene. Int: If item 27 is marked other than "natural", or Iter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 □ Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) than College (1-4or 5+) 11 years Housewife Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) is marked o John Ira Baugher Cora James Lamb ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Peges 1 and 2: Department of Health ar Important: If item 27 is any injury or other traugonce. James Walton (Son) 2718 Lodge Forest Drive Edgemere, Maryland 21219 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 5 Other (Specify) Oak Lawn Cemetery 3/19/2004 Baltimore, Maryland neral Swice to 21. Sign ture of 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Dundalk, Maryland 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 Yes 2 No 3 Probably 4 Dunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autonsy performed certificate 1 Yes 20 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Jursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes XX No Certification: To 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After To the Hospitel or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours To the Funeral The certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) completely 29b. Signature and title of certifier 30. Line and address of person who com Law cause of death (Item 23a) (Type, Print) 2 R 19 Régistrar's Signature State Registrar

			1- For State of Maryland / State of Maryland /	Department of Health and Mo Certificate of Death	ental Hygien Reg. N	2001. 00001
	Dhoraiai		Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	Physici /Media		Wade DESMOND WALK	ker 1	March 12.	2004 1026 A. M
7	Examir	ner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4	c. County of Death
			Sinai Hospital	Baltimore		MR
	Funeral Director	2	5. Social Security Number 6. Sex 1 M 2 F 7. Age (In yrs. last bi	rthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea (Ept 3) /9	9. Birthplace (State or Foreign Country) May Jax
	land		10a. Slate 10b. County 10c. City, Tow	n or Location		10d. Inside City Limits
	Mary f sh	jo	MANYLOND BAIHMINE R.	an Dalls four		1 □ Yes 2-□ No
	r 28a	Director	10e. Street and Number	10f. Zip Code	10g. C	itizen of What Country?
	h with		3669 WATERWHEEL SQUAR	E 2/133		USA
	deat	Funeral	11. Marilal Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Specif Yes, specify Cuban, Mexican, Puerto R	ify Yes or No-	14. Race - American Indian,
21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. Id other then "natural", or Itams 23e or 28e-f show event, I'm Medical Examerer must be notified at	by	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No If Yes, 3 Widowed 4 Divorced Year or Dates:	1 ☐ Yes 2 ☐ No Specify:	ican, etc.)	Specify 3/4 C/C
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and	be fill	Be	17. Father's Name (First, Middle, Last)	Car 1	(First, Middle, Maide	n Sumame)
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Maryland	C1 00 = 00		19a. Inf. mant's Name/Relationship (Type, Print) 19b. 19c. o. Mailing Addr s (Street and Number or Rural	Route Number, City	or Town, State, Zip Code)	
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Baltimore	Pages nent of int: If it		1. Surial 2 Cremation 3 Removal from State / cemete	ry, crematory or other place)	. /	Locaron - City or Town, State
臣			* 4 □ Donation 5 □ Other (Specify) 21. Signature of Suneral Service Licensee	22. Name and Address of Facility (YW)	1 0000	barr /kinglong
Ba	permit. Departr Importa any inji		21. Signature dy uneral Service Cerisee			Inmi Fineral Home
1)-			23a. Part 1. Filler the disease, or complications that caused the death. Do			HOLER, My 21215 Approximate
Ų,	Di		shock, or heart failure. List only one cause on each line.	-\ A	ı	Interval Between Onset and Death
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Вох	The law requires that the death certificate be executed ate has been signed by the attending physician and cage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death	3 □Ectopic pregnancy		23d. Date of delivery
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S	or Attano after death Director: in by the	icat	2 Accident investigation 3 1 Suicide 6 Could not be determined		J	
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	e Ho. 24 h e Fur etely	edicai	29a. Certifier (Check only one) 1 ☐ Certifying Physician: To the best of my knowledge 2 ☒ Medicat Examiner: On the basis of examination an and manner stated.	d/or investigation, in my opinion, death occurred	at the time, date an	d place, and due to the cause(s)
	To the Hospital or Attanding Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Me	29b. Signature and title of certifier	29c. License number	29d. Da	ite signed (Month, Day, Year)
•	2		highi. m.D	O.C.M.E.	Mar	rch 13, 2004
	. 0		30. Name and address of person who completed cause of death (Item 23a) ((Type, Print) 111 Penn Street,	Baltimor	e, Maryland 21201
	Sta	te				
44	Registra		31. Date filed (Month, Day, Year) MAR 1 9 2004 32. Registrar's Signature	book		
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State of Maryland / Department of Health and Men	tal Hygiene 2 1 11.	0
Certificate of Death	Reg. No.	U

PH	WAGNER		For	State	of Ma	ryland / [)ера	ırtmen	t of H	lealth a	and M	lental Hy	ygien	e20	106	08902
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м	Physic	-	1. Decedent's Name (First, Midd.	•								2. Date of D Month		av	Yeer	3. Time of Death
	/Medi		JOSEPH	CARL W	AGNE	R						MARCH	1 17	^{ay} , 20	004	11:39A M
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			SINAI HOSPIT	CAL				BA	LTIM	ORE (CITY			1	N/A	
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	item de	ů	11. Marital Status	12. Was Dec	orces?		13. V	Yes, spec	rfy Cuba	n, Mexicar	n, Puerto	ecify Yes or N Rican, etc.)	0-		ck, White	ncan Indian, , etc.
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Maryland	d a b	To B	George Henry N	Wagner						Agne:	s Kat	herine	Ler	rgenr	mille	er
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85		e	Sequentiatly list conditions. If any leading to immediate cause. Enter Underlying Cause (Disease or injury	b. — Due to	or as a	consequence o	file									
	nted I	Ē	Cause (Disease or injury	S												
	al-tra	Examiner	that initiated events resulting in death) Last	c. Due to	(or as a	consequence o	f):									
68760,	icate be executed physician and s the burial-transit														1	
	ificat g phy as the	edical		- G.												
Вох	death certifi e attending p id for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou										23d. Da	te of deliv	rerv
m	death e atte d for	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Preg	nant at ti	Fetel death me of death		Ectopic pre Other (spe							onth	Day Year
0	that the de red by the a detached	hys	9 🗆 Unknown	9□ Unkr	nown											
٥.	es tha igned be del	by P	Part II. Other significant condition	ons contributing to o	death but	not resulting in	the und	derlying ca	use give	n in Part I.		23e. Did t	tobacco	use cont	ribute to t	the cause of death?
ğ	w requires been sign should be											10	Yes 2	No X	3 Pro	bably 4 Unknown
00	law re as bee 2 sho	Completed										24a. Was	an	24b. \	Were auto	opsy findings available
Be	9 4 9	mo										auto perfo	ormed?	Į į	prior to co death?	impletion of cause of
ta	ician: Th	0	25. Was case referred to medica							26 Place	of Death	1 X Yes) 1	Yes	2LI No
of Vital Records,	Physician: this certific ral director.	0 8	examiner? 1 XYes 2 No	Hospital:	Inpatient	2 ER/Out	Datient	3☐ DO4	Othe			ne 5 Resi		6 🗆 O+-	or (Saa-	4.1
0	g Phy er this ieral c	-	27. Manner of Death	28a. Date	of Injury	28b. Ti	ime of		lc. Injury Work							
ion	nding ath. r: After re funer	atlon;	1 □ Natural 5 □ Pendin 2 🗷 Accident investi	9	nth, Day \	11. 90	jury now:	M	1 🗌 Y	? 'es 2 101	No	Driver &	fa	moto	n veh	icle that estin

To the Hospitel or Attending Pi within 24 hours after death. To the Funeral Director: After the completely filled in by the funera Division

29a. Certifier (Check only one) Medical 29b. Signature and title of certifier

Certification

3 Suicide

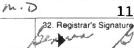
4 Homicide

State Registrar

LING LI 31. Date filed (Month, Day, Yeer) MAR 1 9 2004

no

investigation 6 Could not be determined



3-17-04

m.)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

XX Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number O.C.M.E with another motor vehicle

281. Location (Street and Number or Rural Route Number, City or Town, State) Like Ave a

29d. Date signed (Month, Dey, Year) MARCH 18, 2004

Baltimore

mendowood Rd

			1 - For State Registrar	State of	Maryland / De	epartment of I Dertificate of	Health and N Death	Mental Hygie Reg	200	4 08903
I	Physici /Medie		Decedent's Name (First, Middle, Paschal J.)			2. Date of Death Month MARCH 8		3. Time of Death 2:05 p M
	Examir		4a. Facility Name (If not institution, WASHINGTON COUN		· ·	4b. City, Town, C	or Location of Death		4c. County of I	Deeth
	Funeral Director		062-18-3586	5. Sex 17∑14M 2□ F	7. Age (In yrs, last birtho 78 Yrs	Months Davs	if Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y 11/17/19		Birthplace (State or Foreign Country) Suffalo, NY
	Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County NY	Erie	10c. City, Town o		mherst			10d. Inside City Limits 1 ☐ Yes 2 STNo
	h with the 23a or 28a let be noti	al Director	10e. Street and Number	8 Glen Av	renue	10f. Zip Code	14221	10g	. Citizen of Wha USA	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. It health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, Ite Medical Examine must be notified.	Completed by Funeral	11. Marital Status 1 □ Never Married 2 □ Marrie 3/5 Widowed 4 □ Divorced	Armed Ford 1 X Yes 2 If Yes, Give	No UNK.	13. Was Decedent of H If Yes, specify Cub	dispanic Origin? (Span, Mexican, Puerto	ecity Yes or No- Rican, etc.)		American Indian, White, etc. White
21215-0036	within 72 hour ene. than *natural the Wedical Ex	pleted b	15. Decedent's (Specify only highest Elementary/Secondary (0-12)		16a. Do	acedent's Usual Occup live kind of work done te. DO NOT use retire	during most of work	ing 16	b. Kind of Busin	
	be filed with al Hygiene fother tha svent, the	Be Com	17. Father's Name (First, Middle, La	est)		Cement 1	18. Mother's Name	e (First, Middle, Mai	iden Sumame)	nstruction
Maryland	2 should be and Mental is marked o	To	Dominic 19a. Informant's Name/Relationshi		19b. M	ailing Address (Street	and Number or Run		ity or Town, Sta	te, Zip Code)
	ges 1 and it of Health if item 27 or other tra		Daniel Zamb 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3		20b. Place of Di	17 Richfie sposition (Name of crematory or other plan		Date 200	c. Location - City	
Baltimore,	permit. Pages 1 an Department of Heal Importent: If Item 2 sny injury or other once.		4 □ Donation 5 □ Other (Spe 21. Signature of Funeral Service Li	cify)	P. Doda, Jr.	awn Cemetery Charles L. St	ss of Facility Evens Funer	al Home, In	Buffalo,	
ì			23a. Part1. Enter the disease, or conshock, or heart failure. List or	omplications that cally one cause on a	sed the death. Do not	1501 East Foi	rt Avenue, I	Baltimore Ma	ryland 21	Approximate Interval Between Onset and Death
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)	a. MUL- Due to (o	tole IN	juries				0.130.4110.53411
6	xecuted n and al-transit	Examiner	Sequentially list conditions, leave to the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.	r as a consequence of):					
68760,	ificate be executed g physician and as the burial-transit	edlcal		d						
O. Box	The law requires that the death certificate has been signed by the attending proage 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live birt	nt at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify) _			23d. Date of Month	delivery Day Year
rds, P.	w requires that been signed b should be deta	by	Part II. Other significant condition	s contributing to dea	th but not resulting in th	e underlying cause giv	en in Part I.	23e. Did tobac		e to the cause of death? Probably 4 Unknown
al Records,		Completed						24a. Was an autopsy performed	l? prior	
ot Vit	Physician: Th rthis certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death	Hospital: 1 Ing			er: 4 Nursing Ho	me 5 🗌 Residence		Specify)
Division of Vital	ding Afte fune	Certification:	1 Natural 5 Pending 2 Accident investigat 3 Suicide 6 Could no determine	on 3 - 3 be 28e. Place o	fnjury 28b. Time Injury - O U U (Injury - At home, farm, Injury - At home, farm, I, etc. (Specify)	y Worl	Yes 2 XNo		struct and Number or	refricte Heral Route Number,
ā	To the Hospital or Attano within 24 hours after death To the Funeral Director: completely filled in by the	edical Cer	29a. Certifier 1 ☐ Certifying (Check only 2XMedical Ex	Physicien: To the beminer: On the bas	est of my knowledge, de is of examination and/or	eath occurred at the time	ne, date and place, a	and due to the cause	and place, and o	as stated due to the cause(s)
)	To the within 2 To the comple	Med	29b. Signature and title of certifier	and manne	r stated.	29c. Licens	e number	29d.	Date signed (Mo	onth, Day, Year)
	8		30 Name and address of person wh	o completed cause	ath (Item 23a) (Typ	pe, Print)	Street, B	altimore,	Marylar	nd 21201
	Sta Registr		31. Date filed (Month, (Mary))	9 200 4 ^{32. R}	rar Signature	And			_	

			1 - For Amend Item 18	State of Ma per FH,G829,0	rylar 03/19	id / Depa 0/04d /de /	artmer <i>rtificat</i>	t of H	ealth a Death	and M		gienę Reg. No.	2004	08	904
	Dhysici	an an	1. Decedent's Name (First, Middle, Las	t)			Mon								
	Physicia /Medic	al .	LOUIS					NN			MARCH_	15, 2	2004 County of Dear	9:20	РМ
	Examin	er	4a. Facility Name (If not institution, give 9201 JAMES HOWAF				46. City,		Location of			46.	BALTI		
	Funeral		5. Social Security Number 6. Se		(In yrs.	last birthday)		1 Year	If Under			h Voar		thplace (State	or Foreign
L	Director		130-01-7647	XM 2DF	88	Yrs.	Months	Days	Hours	Min.	8. Date of Bird (Month, Da SEPT. 9	,191	5	N	J
	and w	-	Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							10d. Inside	City Limits
	Manyl	ō	MD BALTI	MORE					PIKE	SVIL	LE			1 □ Ye	s 2 No
	r 28a	Director	10e. Street and Number				10f. Zip	Code				10g. Citi	zen of What Co	ountry?	
	23a c		9201 JAMES HOWARE	LANE					2120					U.S.A	•
	er dee	Funerai	11. Marital Status	12. Was Decedent E Armed Forces? 1 X Yes 2 ☐ No		.S. 13.	Was Dece If Yes, spe	dent of Hi cify Cubai	spanic Ori n, Mexican	gin? (Spe i, Puerto I	cify Yes or No Rican, etc.)	-	 Race - Ame Black, Whit 		
36	al', or	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	,		1 🗆 Yes	21 X No	Specify:				Specify:	WHITE	
21215-0036	d within 72 hours after deeth with the Maryland piene. Ir than "natural", or Items 23a or 28e-f show the Medical Examiner must be neillied at	ted	15. Decedent's Ed	de a marchada add		16a. Dece	dent's Usu	al Occupa	ation during most	t of workii	na	16b. Ki	nd of Business	Industry	· · · · · · · · · · · · · · · · · · ·
2	othin ne. han	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	·) 5		CHOL(11 5	. GOVER	NMENT	
	be filed watal Hygie od other to		17. Father's Name (First, Middle, Last)		υT	P31	CHOLC	0131		r's Name	(First, Middle,			MILINI	
an	Q 22 D .	To Be	HERZL			ZINN			Ct	ARA	KLARA			SCHWAF	RTZ
Maryland	2 m m		19a. Informant's Name/Relationship (7	ype, Print)		1	-						r Town, State,		Ti-
-	fealth m 27 her tr			SON	20h 1	7 WO		and the same	ACE -		NGS MII		MD 211 cation - City or		
JOL	m Q		20a. Method of Disposition 1		1 '	TIMORE	natory or o	other place	· 1				EISTERS		MD
Baltimore	그 본문공 .		*4 □Donation 5 □Other (Specify 21. Signature Feral Service Licen	- 1//	DAL				and the same of th		-		BROS.		MD
Ba	Depa Impo eny ir		Muchael	Trus	n								SVILLE,		208
	Physician		23a. Part1. Enter the disease, or components, or heart failure. List only Immediate Cause (Final disease or condition	plications that paused one caused line	the dear	th. Do not ent	er the mod	de of dying	g, such as	cardiac o	r respiratory a	rrest,		Approxim Interval B Onset an	etween
	/Medical Examiner		resulting in death)	Due to (or as a	consec	quence of):	1 1		Drs.					12	Bars
	LAMINIE	-	Sequentially list conditions,	b. Due to for as a	consec	ue ve of):	rye	7 1	Vs.	us	e-			209	ears
	uted d ansit	Examine	n any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			0		4						,	
o,	ate be executed thysician and the burial-transit		resulting in death) Last	Due to (or as a	consec	quence of):									
8760	ate be hysici the bu	dical		d			<u>-</u>				<u>_</u>				
9	eath certific attending p	/Mec	IF FEMALE:	23c. If yes, outcome of	of prean	ancv							23d. Date of de	livery	
Box	atten atten	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 ☐ Live birth 2 4 ☐ Pregnant at t	Feta	aldeath 3[Ectopic p Other (s					1	Month	Day	Year
Ŏ.	at the de by the a	hysi	9 Unknown	9□ Unknown											
S, P	es tha	by P	Part II. Other significant conditions of	ontributing to death bu	t not res	sulting in the u	nderlying	cause give	en in Part I.				se contribute to		f death? Unknown
ord	w requir been si should		Monten ac	senden	d	120	Mrs.				-	Yes 2			
3ec	e law has b	Completed	Vancrestic	-Dilsan	7	caro	ika	ha	-		24a. Was autop perfo		death?	completion of	s available cause of
al	(0)	e Co	25. Was case referred to medical						ne Place	of Doath	1 Tes	2 No	1 ☐ Yes	2 □ No	
of Vital Record	Physician: this certific ral director,	To Be	examiner?	Hospital:	nt 2	ER/Outpatier	nt 3 ☐ D	OA Othe					6 □Other (Spe	cify)	
	ding Ph h. Atter th funeral		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injun (Month, Day	Year)	28b. Time o Injury	f	28c. Injury Work	at k?	2	28d. Describe i	now injur	y occurred		
Division	Attending r death.	Certification:	2 Accident investigation 3 Suicide 6 Could not be				М		Yes 2 🗌		206 Leasting (Ctroot an	d Number or Ri	um l Bauta Ali	mbor
) ivi	i Sir e	ertifi	4 Homicide determined	28e. Place of Inju building, etc	(Speci	fy)	reet, factor	y, office		1	City or To			urai moule ivi	imber,
	To the Hospitel or within 24 hours after To the Funeral Dir completely filled in			ysician: To the best o											
	To the Hospite within 24 hours To the Funeral completely filled	edical	(Check only 2 Medical Examone)	niner: On the basis of and manner star		ation and/or in	vestigation	n, in my op	pinion, dea	th occurr					
	J To the Hospitel within 24 hours a To the Funeral I completely filled	Σ	29b. Signature and title of certifier	101		. 1	29	c. License	number) ~		M	e signed (Mont		
	16		Xawrence	Holom	<u></u>	_M()	Print)	V1	63.	_2	- (" (a	rch 16	208	74
12	1		30. Name and address of person who	completed cause of de	am (Ite	1823 (Type,	- CF	ces	e Ti	ree	Roa	d	21	208	
	Sta		31. Date file Amarhi Dan Yanna	32 Registra	r'a Sign	aty						-		- v	
	Registr		Ryan .			-									

			1 - For State Registrar	State o	f Marylar		artmen rtificate					eg. No.	Z 11 11 11	08905
	Dhuaiai		1. Decedent's Name (First, Middle, La	st)							2. Date of Deat Month	th Day	Year	3. Time of Death
	Physici /Medio		Jane Riley Art								Februar	7		6:19 A.M
7	Examir		4a. Facility Name (If not institution, given	re street and nur	mber)		,		Location of	of Death		4c.	County of Dea	th
			7121 Ayers Lan					w Hi		24 Hrs	0.0		Worcest	
н	Funeral			Sex 1 □ M 2 🖾 F	7. Age (In yrs.		If Under Months	Days	If Under	Min.	8. Date of Birth (Month, Day,	Year)		thplace (State or Foreign ountry)
	Director		216-14-3382 Usual Residence of Decedent		86) 113.					July 29	<u>, 19</u>	17 Mar	yland
	land		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation	-						10d. Inside City Limits
	Mary	ō	Maryland Worce	ctor	Sr	now Hil	1.							1 ☐ Yes 2 🖾 No
	28e	rec	10e. Street and Number	BCCI			10f. Zip	Code			1	0g. Citi	zen of What Co	ountry?
	3a o	O E	7121 Ayers Lane	Road			21	863				U.	S.A.	
	72 hours after death with the Maryland natural', or items 23a or 28e-f show dical Exaction from the redified at	Funeral Director	11. Marital Status	12. Was Dece	edent Ever in U	I.S. 13.	Was Deced	lent of Hi	spanic Orig	gin? (Spe	ecify Yes or No- Rican, etc.)		14. Race - Ame Black, Whit	
9	or Ite	Ē	1 ☐ Never Married 2 ☑ Married	1 Tes	2 (X) No		1 ☐ Yes 2	•	Specify:	i, i deito	rtican, etc.)		Specify:	e, etc.
ဗ္ဗ	ours	d by	3 Widowed 4 Divorced	Year or D	ates:			AR 110					W. W.	hite
Ϋ́	72 h	Completed	15. Decedent's E (Specify only highest gr			16a. Dece (Give	dent's Usua kind of wor DO NOT us	k done d	ition Juring most	t of worki	ing	16b. Kir	nd of Business	/Industry
12	within ene. than	ш	Elementary/Secondary (0-12)	College (1	-4or 5+)		phone					Тρ	1ephone	Company
S	be filed within 72 hours after death with the Marylan Ital Hygiene. od other than "natural", or Items 23a or 28e-f show event, the Medical Exactiver must be rediffed at		12 17. Father's Name (First, Middle, Last	1		1010	phone	Opc			(First, Middle, I			. company
ano	ntal led o	Be c	Sewell Thomas Ri								ne Pusey		,	
Ë	should be ind Mental marked c	ဥ	19a. Informant's Name/Relationship			19b. Mailir	n Address	(Street a			I Route Number		Town, State.	Zia Code)
Maryland 21215-0036	nd 2 s lith an 27 is r trau		Lewis D. Arthur	(husba	nd)		Ayer	`			Snow H			1863
	1 468 E 4		20a. Method of Disposition	(Habba	20b. I	Place of Dispo	sition (Nam	e of					cation - City or	
Б			1 Burial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Speci		State Sno	cemetery, crer W Hill Irch Ce	Chri	stia	n in	2-27	-2004	Snow	, ц : 11	Maryland
Baltimore,	コモモラ		21. Signature of Funeral Service Lice		IGHT	22	. Name and	d Addres	s of Facility	у	2004	JIIOW	, 11111,	Haryrand
ä	Departing Important		Por sweed			Sh	ort F		al Hove St		: Delm	ar	DF 10	940
			23a, Part1, Boter he disease, oc com	plications that c	aused the deal	th. Do not ent							<u> </u>	Approximate Interval Between
a.	Physician		shock, or heart failure. List only Immediate Cause (Final	-ene cause on e	A D	11	70	5	EI	100	511			Onset and Death
Z.	/Medical		disease or condition resulting in death)	a Due to (or as a consec	uence of):			E		7 63			466-3
	Examiner													
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consec	juence of):								
	cutec nd ransi	Examiner	that initiated events	c			**							
oʻ	ate be execui hysician and the burial-trar	EX	resulting in death) Last	Due to (or as a consec	luence of):								
8760,	rate be executed hysician and the burial-transit	lical		_ d										
<u> </u>	death certifics e attending ph id for use as t	Physician/Med	IF FEMALE:	20 - 11						-				
Вох	ath c	lan/	23b. Was decedent pregnant in the past 12 months?		inth 2 ☐ Feta	ıl death 3 ☐	Ectopic pre					2	3d. Date of del Month	ivery Day Year
<u>.</u>	the deay the a	/sic	1 ☐ Yes 2 Mo 9 ☐ Unknown	4∐Pregn 9□Unkno	ant at time of o own	leath 5∟] Other (spe	ecity)						,
P.0	uires that the de signed by the a ld be detached f	F.	Part II. Other significant conditions	contributing to de	eath but not res	sulting in the ur	nderlying ca	use nive	n in Part I.		23e. Did tob	acco us	se contribute to	the cause of death?
Records,	The law requires that ate has been signed b page 2 should be deta	d by					, ,				1 □ Ye	s 2[]No 3 ☐ Pr	obably 4 Sunknown
Ö	w requir been si should I	Completed									04- 146		045 14/200 201	A Carlana a callabla
3ec	has has ge 2 s	μ									24a. Was ar autops	y	prior to death?	topsy findings available completion of cause of
a E	ysician: The is certificate hi director, page										1 ☐ Yes 2	No.	1 🗆 Yes	2□ No
<u> </u>	ilcian: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othe			(Check only one			
Division of Vital	# = F	2	1 ☐ Yes 2 XNo 27. Manner of Death	28a. Date 0		ER/Outpatien 28b. Time of		^_	4 Nul	rsing Hor	ne 5 X Teside 28d. Cescribe ho		Other (Specocurred	cify)
O	ding h. After fune	ţ	1 Natural 5 ☐ Pending 2 ☐ Accident investigatio	(Mont	h, Day Year)	Injury	м	3c. Injury Work 1 □ Y	? 'es 2 □ N		100000000000000000000000000000000000000			
İS	Attend death ctor: /	fica	3 ☐ Suicide 6 ☐ Could not b	e 28e. Place	of Injury - At h		eet, factory,	office		2			Number or Ru	ıral Route Number,
<u>S</u>	after after Dire	Certification:	4 Homicide determined	buildir	ng, etc. (Specil	<i>y)</i>	·				City or Town	, State)		
	To the Hospitel or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical C	29a. Certifier 1 Certifying Pl	nysician: To the niner: On the ba and manr	asis of examina	owledge, death	occurred a restigation,	at the time in my op	e, date and inion, deat	d place, a	and due to the ca ed at the time, da	use(s) ate and	and manner as place, and due	stated. to the cause(s)
	o the	Me	29b. Signature and title of certifier				29c.	License	number		29	d. Date	signed (Monti	h, Day, Year)
	⊢ s ⊢ ŏ		1///				1	128	353			21	24/04	
			30. Name and address of person who	completed caus	e of death (Iten	n 23a) (Type		200		A	0	~[21101	
Q			Rone Desman	isma	40	OEas	terr	131	more	Dr	Salis	will	A WE	21804
	Sta	te	31. Date filed (Month, Day, Year)		egistrar's Signa	ature /	/	,	,					
	Registr	ar	FEB 2 5 2	2004	Depena		De	ock.						

DHMH 17 Rev 1/2001

			For State	State of Mar	ryland / Depa	artment of h	lealth and	Mental Hygi	ene g. No. 2004	08906
			Registrar 1. Decedent's Name (First, Middle, Las			rimeate or	Douin	2. Date of Death	g. No 1	3. Time of Death
	Physici	an						March 2,	extstyle e	12:30 AM
my	/Media					4. 01. 7	-1			12:30 A
1	Examir	ner	4a. Facility Name (If not institution, give				or Location of Dea		4c. County of Death	
			Calvert Memoria	-			e Freder		Calver	
	Funeral		5. Social Security Number 6. Se		(In yrs. last birthday) 78	If Under 1 Year Months Days	Hours Min	n. (Month, Day,	Year) 9. Birthp	place (State or Foreign htry)
	Director		314-22-0023		0 113.			Jan 26,	1926 Ind	iana
	2 2		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				0d. Inside City Limits
	sho	-	MD Anne Ar							1 ☐ Yes 2 No
	₩ 99 ¥	Sct		runder	Friendsh	-		1.0	0.00	
	्रे के कि	Director	10e. Street and Number			10f. Zip Code	50	10	g. Citizen of What Cour	itry ?
	I within 72 hours after death with the Maryland liene. r then "netural", or Items 23a or 28e-f show the Medical Esacified most be notified at	-E	6975 Kim Lane			207			USA	
	r de	Funerai	11. Marital Status	12. Was Decedent Ev Armed Forces?		Was Decedent of I If Yes, specify Cub	Hispanic Origin? (an, Mexican, Pue	(Specify Yes or No- erto Rican, etc.)	14. Race - Americ Black, White,	
9	or II		1 ☐ Never Married 2 ☑ Married	1 ☐ Yes 2√2 No If Yes, Give	2	1 ☐ Yes 2 ☒ No	Specify:		Specify: Wh	ite
Ö	in in in in in in in in in in in in in i	d by	3 Widowed 4 Divorced	Year or Dates:						
Ϋ́	72 t	Completed	15. Decedent's Ed (Specify only highest gra-	ucation de completed)	16a. Dece (Give	dent's Usual Occup kind of work done DO NOT use retire	pation during most of w	rorking	6b. Kind of Business/In	dustry
7	within ene. then	ld L	Elementary/Secondary (0-12)	College (1-4or 5+)		<i>a)</i>		Moset es es D	1
7	filed with Hygiene. Ither thei	S	12		seci	etary	40.44-15-4-11	(5i 16i-d-11- 14	Mortgage B	ankrug
Maryland 21215-0036		Be	17. Father's Name (First, Middle, Last)					ame (First, Middle, M		
<u>×</u>	should be and Mental s marked o umatic eve	2	Willard Verle	Martin			Thelm		Millpaul	
<u>a</u>	C = 0		19a. Informant's Name/Relationship (7						City or Town, State, Zip	Code)
	1 and Health em 27 ther tr		Mundell Anders	(husband)				ship. MD_	20758	
Sre	S TO TO		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Damoual from State	20b. Place of Dispo cemetery, cres	osition (Name of matory or other pla	ce) Ma	r^{D}	Oc. Location - City or To	wn, State
Ĕ	Pages ment of ent: If it		'4 □Donation 5 □ Other (Specify		Cedar Hi	11 Cemete	ery 2	004	Suitland, M	D
Baltimore,	artin orte inju		21. Signatur of Juneral Service Licen	S00	22	2. Name and Addre	ss of Facility L	ee Funeral	Home Calv	ert, PA
ä	Depa Impo any ii		Cary J. Gold		8	125 South	hern Mar	yland Blvd	d. Owings,	MD 20736
			23a. Part 1. Enter the disease, or comp	lications that caused the	ne death. Do not en	ter the mode of dyin	ng, such as cardi	ac or respiratory arre	st,	Approximate Interval Between
			shock, or heart failure. List only a Immediate Cause (Final	Me cause on each line	lan	2 4	12.00		¥.	Onset and Death
1	Pnysician /Medical		disease or condition resulting in death)	a. Due to (or as a	consequence of):	11111411	mig		/	ominutes
	Examiner			Acuto	Tro Povi	w Mari	מיל לתימים	1 infanc	Linn	6 Howis
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a	consequence of):	or range	scora ja	i miure	TION	i i i i i i i i i i i i i i i i i i i
	nsit	nin	cause. Enter Underlying Cause (Disease or injury							
•	be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a	consequence of):		•			
760,	be e iician buriz	calE								
	eath certificate be executed attending physician and for use as the burial-transit		•	d						
×	ding se as	/Me	IF FEMALE:	23c. If yes, outcome of	pregnancy				23d. Date of delive	10/
Вох	atten for u	ian	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 4 Pregnant at ti	Fetal death 3	Ectopic pregnancy Other (specify)	У		Month	Day Year
o.	that the de led by the a detached	Physician/Medi	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9 Unknown	me or death 5L					
P.O.	hat the d by detac		Part II. Other significant conditions of	antributing to death but	not resulting in the u	nderlying cause giv	en in Part I	23e. Did toba	acco use contribute to the	e cause of death?
Vital Records,	Se us	Completed by	Pneumonia		nodenm				2 No 3 Prob	_
50	w requir been si should	tec		, 0010	1 11	4,		12		
ec	elaw hasb je2st	ğ	Supra ventricul	ar arri	nythmi	<i>u</i> ·		24a. Was an autopsy	prior to con	psy findings available npletion of cause of
		5	,					perform 1 □ Yes 2	ed? death? ∃No 1 ☐ Yes	2□ No
ita	ysicien: Th is certificate director, pag	Be	25. Was case referred to medical examiner?					eath (Check only one)	
_	S S E	ို	1 ☐ Yes 2 ☑ No	Hospital: 1 [Inpatient	2 ER/Outpatier	nt 3□ DOA Oth	1er: 4 ☐ Nursing	Home 5 ☐ Resider	ice 6 Other (Specify)
0	Attending Physicien: r death. ector: After this certific by the funeral director,		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Time o	f 28c. Injur Wor	y at rk?	28d. Describe hov	v injury occurred	
<u></u>	endi sath. or: A he fu	ati	2 Accident investigation			M 1 🗆	Yes 2 □ No			
Division of	r Att	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc.	y - At home, farm, str <i>(Specify)</i>	reet, factory, office		28f. Location (Streetly or Town,	eet and Number or Rura State)	l Route Number,
	itel o rs aft rel Di ted ir			N N						
	To the Hospitel or Attending Phywithin 24 hours after death. To the Funerel Director: After thi completely filled in by the funeral	dical							ise(s) and manner as st e and place, and due to	
	To the h within 24 To the F complete	O O	one)	and manner state						
	To To Con	Σ	29b. Signature and title of certifier	(6		29c. Licens			d. Date signed (Month, i	* * * * * * * * * * * * * * * * * * * *
			· Lega	1-6 DW	rana.	1 25	U U D D		3-2-20	69
	1		30. Name and address of person who of 5851 - Decc	completed cause of dea	ith (Item 23a) (Type,	Print) Gy	an . c.	SURAND	9	
	1			le chwill	nton A	road	Deale	_ m.D	20751	
	Sta		31. Date filed (Month, Day, Year)	32. Registra	s Signature	- AU				
	Registr	ar	MAK U	4 2004	BELLER SK	SORAL S	7			

			For State Registrar	State of I	Maryland	/ Depa	artment of H rtificate of L	ealth a Death	and Mental F	lygiene Reg. No	<u>5001</u>	08907
	<u> </u>		1. Decedent's Name (First, Middle,	Last)					2. Date of Month		y Yea	3. Time of Death
	Physicia /Medic		Herbert	C			Aleshire	2	March	Da 5	2004	12:50 P M
	Examin		4a. Facility Name (If not institution,		er)		4b. City, Town, or		of Death	40	. County of De	
			18611 Preston F				Hagerst		2411		Washir	
	Funeral Director		5. Social Security Number 173-03-3094	5. Sex 7. 1 ☑ M 2 ☐ F	Age (In yrs. las 91	t birthday) Yrs.	If Under 1 Year Months Days	If Under a		Day, Year))	Birthplace (State or Foreign Country) Lrginia
	pu ,		Usual Residence of Decedent 10a. State 10b. County		10c. City, 7	Tour or Le	eation					10d. Inside City Limits
	anyla shov	_										1⊠Yes 2□No
	8e-f	Directo		ngton	Ная	gerst	OWN 10f. Zip Code			100 Ci	tizen of What	
	with t		10e. Street and Number								USA	oodinity:
	s 23	eral	18611 Preston Ro	12. Was Decede	ent Ever in I.I.S.	13	21742	spanic Orio	nin? (Specify Yes or			merican Indian,
	ter d	Funeral	1 ☐ Never Married 2 ☐ Marrie	Armed Force	es?	ł		n, Mexican	gin? (Specify Yes or , Puerto Rican, etc.)		Black, W	hite, etc.
99	urs af	ē	3	If Yes, Give Year or Date			1 ☐ Yes 2 🔯 No	Specify:			Specify: W	nite
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28e-f show the Medical Examinar mast be notified at	Completed	15. Decedent's	Education		16a. Dece	dent's Usual Occupa	ation	t of working	16b. K	(ind of Busine	ss/Industry
3	thin 7 e. en "n Med	ple	(Specify only highest Elementary/Secondary (0-12)	College (1-4	or 5+)		kind of work done of DO NOT use retired)	or working			•
7	er th	Con	9			Mecha	anic				irchild	i
g	d oth	Be	17. Father's Name (First, Middle, La						r's Name (First, Mid			
Maryland	ould Men Marke	은	Luther Martin			721 UT W			a Belle S			7.0.40
Nar	h and h and l is n	11 9	19a. Informant's Name/Relationship				•		or or Rural Route Nut , Hagerst		allia a a	1,742
e,	of Health aritem 27 is		David L. Aleshi: 20a. Method of Disposition	re/son	20b. Plac	e of Dispo	sition (Name of	- 1	Date			or Town, State
Ď	nt of nt of nt of nt of		1 X Burial 2 ☐ Cremation 3		916	-	matory or other plac		/9/2004	Час	oretora	n, Maryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Medial Hygiene. Important: If item 27 is marked other than "naturat, or Items 23a or 28e-f show appringury or other traumatic event, the Medical Examinating the rediffied at ance.		' 4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Signature Control		Rest		en Cemete: 2. Name and Addres	-	Rest Hav			
Ba	Departiment of the second of t		I En Tu	15-	_							n, Md. 21742
			23a. Part1. Enter the disease, or c shock, or heart failure. List or	omplications that cau	sed the death.							Approximate Interval Between
L	Pnysician		Immediate Cause (Final disease or condition	Rear	1	0-	- adin	P	eum on	1		Onset and Death
	/Medical		resulting in death)	- a	as a conseque	nce of	(Pour Con	100	CUM, ON			(ew.c.
	Examiner		Sequentially list conditions.	b. 1045	and the second second							
-	D ti	Examiner	Sequentially list conditions, any leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a conseque	ce of):	1		1 1			
	and	xam	that initiated events resulting in death) Last	c. A Yas	e 105 as a conseque	nce of):	tec va	sau	la di	295	T	
8760,	death certificate be executed e attending physician and of for use as the burial-transit											
687	icate phys s the	dic	_	d								
Box (eath certific attending pl	Z/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco							23d. Date of	delivery
-	death e atte d for	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 <u>□</u> Pregnan	h 2□Fetel de nt at time of dea		<pre>JEctopic pregnancy J Other (specify)</pre>			_	Month	Day Year
P.0	that the de ted by the a detached	hys	9 Unknown	9□ Unknow	n							
	law requires that the as been signed by th 2 should be detache	by P	Part II. Other significant condition	s contributing to deal	th but not resulti	ng in the u	nderlying cause give	en in Part I.		.4		to the cause of death?
ğ	w require been si should I	P G	Chronec OSSV	Tru come	Cem	< 11	156454	_	>	Yes 2	!□No 3□	Probably 4 □Unknown
Vital Records,	has bei ge 2 sho	Completed	Dementia						24a. W	topsy	prior t	autopsy findings available o completion of cause of
<u>۳</u>	ate pag	Son							1 ☐ Ye	s 200 No	death	? es 2□ No
/ita	i cian: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Magaitale			Othe		of Death (Check on	ly one)		
	Physic this cal dire	၉	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inp		VOutpatier 8b. Time o	1 3 DUA	4 LINU	rsing Home 528			pecify)
uc	ding l	ion	1 Natural 5 ☐ Pending	(Month,	Day Year)	Injury	Work	<br Yes 2 🗀 I		30 110 11 11 10	ny occurred	
Division of	Attending Physician: If death, ector: After this certific by the funeral director,	ficat	3 ☐ Suicide 6 ☐ Could no	ot be 28e. Place of	Injury - At hom	e, farm, st	reet, factory, office		28f. Locatio			Rural Route Number,
<u>S</u>	al or safter	Certification:	4 Homicide	building	, etc. (Specify)				City or	Town, State	θ)	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical C	(Check only 2 Medical E	Physician: To the be xeminer: On the bas	is of examination	edge, deat n and/or in	h occurred at the time vestigation, in my of	ne, date an pinion, dea	d place, and due to t th occurred at the tin	he cause(s ne, date an	and manner d place, and d	as stated. ue to the cause(s)
	To the I within 2. To the I complet	Med	one) 29b. Signature and title of certifier	and manne			29c. License	e number		29d. Da	ate signed (Mo	onth, Day, Year)
	₹ <u>₹</u> 8		VIIIau 6 1/1	nen- h			17.3	815		Ma	rch.	5 2004
	2		30. Name and address of person w	to completed cause	of death (Item 2	(3a) (Tyne	Print)		4			•
Y	*		Mary & Manel	1 mD 35	4 411	SY	est, H.	eser	stown,	mb	0 2	740,
	Sta Registi		31. Date filed (Month, Day, Year)	2004	gistrar's Signatui	9. A	pere					inth, Day, Year) 5 2004

		•
State of Maryland	Department of Health	and Mental Hygiene

		Certificate of Maryland / Department of Health and W		g. No. 2004	08908
	Physicia	Decedent's Name (First, Middle, Lest) EVANGELINE S. BOWSER	2. Dete of Deeth		3. Time of Death
100	/Medica	Ab City Town or I		4c. County of Death	1:15pm
	Examine	Ruxton Health of Denton Dento		Carolin	e
Ø.	Funeral Director		8. Date of Birth (Month, Day, Nov 2 I	9. Birthp	place (State or Foreign http:// ch Carolin
	dand	Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		1	0d. Inside City Limits
	e Mary	MD Caroline Greensboro			1⊠Yes 2□No
	with th	MD Caroline Greensboro 10e. Street end Number 13200 Greensboro Rd., Lot 8 21639 11. Merital Status 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married	10	g. Citizen of Whet Cour	itry?
	ne 23	13200 Greensboro Rd., Lot 8 21639 11. Merital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spe	ecify Yes or No-	U.S.A.	an Indian.
Baltimore, Maryland 21215-0020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health end Mental Hygiene. Important: if item 27 is marked other than "naturel", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examinar must be notified at once.	11. Merital Status 1 □ Never Married 2 □ Married 1 □ Never	Rican, etc.)	Black, White,	
	vuld be filed within 72 hours e Mental Hygiene. Irked other than "naturel; o rtic event, the Medical Exan	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of workli (ife. DO NOT use retired)	ing 16	6b. Kind of Business/Inc	iustry
212	y within	Elementery/Secondary (0-12) College (1-4or 5+) Nurse's Aide		Health Ca	re
ם	al Hyg	17. Father's Name (First, Middle, Last) 18. Mother's Name	(First, Middle, Ma		
<u> </u>	d Menid	Lowell Stevens Julia N			
S S	nd 2 sl lith en 27 ia n r traur	19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Julie M. Odenweller (daughter) 4002 Green Tree	Ave.	City or Town, State, Zip Sarasota.	Code) 34233
ore,	of Head of Head of Head	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)		Oc. Location - City or To	
Ĕ E	Pag tment tant: if jury o	4 Donation 5 Other (Specify) Glenwood Cemetery 3/		Smyrna, I)E •
Bai	Departing Department of the partment of the pa	21. Signature Funeral Service nsee M00510 22. Name and Address of Facility Matthews-Bryson 123 W. Commerce	Funera St. Sm	1 Home yrna, DE.	19977
-		23a. Party Enter the diseese, of complications that caused the death. Do not enter the mode of dying, such as cardiac o			Approximate Interval Between
Ì	Physician /Medical	Immediate Cause (Final	C	4	Onset and Death
ł.	Examiner	Immediate Cause (Final disease or condition resulting in deeth) e. Cute myocardial Due to (or as e consequence of):	mar	acon	Ψ
	pe tist	b			
,	death certificete be executed e ettending physician and ad for use es the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury c.		1	
68/60,	ste be	Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of):		-	
õ ×	2 2 2			1	
ô n	eath cer ettendin i for use				
		Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did tobs	acco use contribute to	the cause of death?
ś	requires thet the neen signed by the hould be deteche	Suprasellar mass			,
ecords,	beer shou	Hypertenscon	24a. Was an a performe	d? ava	re autopsy findings ilable prior to apletion of cause leath?
I,	Attending Physician: The law ar death. •ctor: After this certificate has by the funeral director, page 2		1∐ Yes		Yes 2□ No
VIEW.	Physician: this certific ral director,	25. Was case referred to medical examiner? 26. Place of Death		-	
	Physic rthis c anal din	1 Inpatient 2 EH/Outpatient 3 DOA Servirsing Hom	ne 5 Residence 28d. Describe how	ce 6 ☐Other (Specify)
VISION	Attending or death. ector: After by the fune	1/SeNatural 5 □ Pending (Month, Dey Year) Injury Work? 2 □ Accident investigation M 1 □ Yes 2 □ No		, ,	
	tal or Attending P Is effer death. al Director: After the did in by the funera	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Stree City or Town, S	et and Number or Rural Stete)	Route Number,
	spital of nours and nours	29a. Certifier 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, as	nd due to the sau	swist and mannar as str	ded
	Vo the Hospital or within 24 hours effer To the Funeral Dir completely filled in		d at the time, date	and place, and due to	the cause(s)
	With Tot	29b. Signature and title of certifier	29d	Date signed (Month, L	Pay, Year)
	11	30. Name and Tress of person who completed cause of deeth (Item 23a) (Type, Print)		3/7/04	
	4	30. Name and these of per in who completed cause of deeth (Item 23a) (Type, Print) ANDROP AUCH ND 2195 Washing &	tm St	-Easton	mDZ1601
	State	31. Date filed (Month, Day, Year) 32. Registrar's Signature			

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** BULKELEY 02 04 **PEGGY** ANN 22 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner medical NICONICO 542/56UN RegIONAL PENINSULA If Under 1 Year If Under 24 Mrs. 8. Date of Birth (Month, Day, Year) JUNE 29, 1961 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Min. 1 □ M 2 1 F MARYLAND 42 221-54-6346 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a. State 10b. County itam 27 is marked other than "naturel", or Itams 23a or 28a-1 show other traumatic event, the Modical Examiner must be notified at 1 Yes 2 No Director SELBYVILLE DELAWARE SUSSEX 10g. Citizen of What Country? 10f. Zip Code 10a. Street and Number death with 19975 USA 106 WEST CHURCH STREET Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) d be filed within 7 intal Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) CUSTOMER SERVICE REP. CABLE 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mental JONES JAMES FRAMPTON WILLIA Pages 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health ar Important: If item 27 Is eny injury or other trau QDGs. JOHN T. BULKELEY JR./HUSBAND P.O. BOX 591, SELBYVILLE, DELAWARE 19975 Itimore, 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State BISHOPVILLE CEMETERY 2/26/04 BISHOPVILLE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 Part 1. Enter the disease, or complications that caused the ceath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ustrum Physician 10 VO disease or condition resulting in death) Trony 2 m /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) ner I-transit The law requires that the death certificate be executed Exam Due to (or as a consequence of) burialby Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year ō in the past 12 months? 5 Other (specify) ed by the a ☐ Yes 2 ☐ No o. 9 Unknown م 23e. Did tobacco use contribute to the cause of death? bengis d be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Ż√ŽÎNo 3 Probably 4 Unknown 1 Tyes Completed peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has certificate 1 ☐ Yes 2 No 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes _2 No P 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: After t 1 Natural or Attending 5 Pending 1 ☐ Yes 2 ☐ No investigation death. 2 Accident the Funaral Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours after To the Funaral Dire 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 20507 04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Joseph A! SHUSBNE B CARROLL ST GRALLO 145 32. Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 2 5 2004 Registrar

DHMH 17 Rev 1/2001

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State of Maryland / Department of Health and Mental Hygiene 004 For State Ragistrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Leola Bush march 64 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1+17293 Haure Sir HOME brace 7. Age (III.) Year If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🕽 F Months NE NE 213-18-3098 Yrs 11-14-1904 Director Usual Residence of Decedent filed within 72 hours after deeth with the Maryland 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 21 No Directo Oxford Chester 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? USA 19363 401 Lancaster Pike Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☑ No þ 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Retail Sales Clerk 12 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event SIMB. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mary B. Shaw Archabald L. Akers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 401 Lancaster Ave., Oxford PA 19363 <u>Pauline M. Fagan</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition MBurial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 3-10-2004 Memorial Park St. Petersburg, FL 21. Signature of Fungral Service Ligensee 22. Name and Address of Facility Oxford, PA 19363 86 Pine Street Edward L. Collins Funeral Home, Inc., Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician preumonia Zweeks Aspuratur /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury Due to (or as a consequence of): Examiner use as the burial-transit that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) page 2 should be detached this certificate has been signed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Althemers Disease 1 ☐ Yes 2 ☑ To 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐No 1 ☐ Yes 223 No director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: Certification: To 1 Yes 25No 1 | Inpatient 2 | ER/Outpatient 3 | DOA ursing Home 5 Residence 6 Other (Specify) funeral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred after death. I Diractor: After t Hospital or Attending Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 0 hall ws 200048050 4104 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , n.D. 15 South Parke Street #400 Aberdeen MD 21001 Shukla 32. Registrar's Signature State Registrar

Jush. Leal

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2/23/04 REBECCA /Medical RUTH BRADLEY 7:30 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner RUXTON NURSING HOME. (In yrs. last birthday) DENTON , MD

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. CAROLINE Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 TF Director 218-16-9220 83 8/18/1920 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County **Work** ne 23a or 28a-f ahov 1₩Yes 2 No Director Wicomico Hebron the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 300 East Walnut 21830 St death America Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give filed within 72 hours after 1 □ Never Married 2 □ Married 0 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specity: White 3 Widowed 4 Divorced Year or Dates: "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Home Maker 6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Gertrude Lankford Luther Lord 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3406 Rose St., Feder1sburg, Md 21632
Date 20c. Location City or Town, State John Wells Sr, Son 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. * 4 □ Donation 5 □ Other (Specify) Springhill Memory Gardens Hebron, Md 21. Signature of Funeral Service Licenses Messick Funeral Home, P.O. Box 61 m00416 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 196 strutue florera 6M Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown þ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a. Was an certificate has b autopsy performed? 1 Yes 2 No or Attending Physician: director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 ursing Home 5 Residence 6 Other (Specify) မ 1 Yes 2 No 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Matural 5 Pending Injury 1 ☐ Yes 2 ☐ No death. 2 Accident investigation within 24 hours after death To the Funeraf Director: , completely filled in by the f 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier 2/25/2004 131036 30. Name and address of person who completed cause of death (Item 23a) (Type, Print), Drue Chester Mis 21619 710817 Don 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 0 2 2004 Registrar

DHMH 17 Rev 1/2001

			1 - State of Maryland / Dep Registrar Ce	artment of Health and Mental Fertificate of Death	Hygiene 2004 08912
	Physici /Medio		1. Decedent's Name (First, Middle, Last) Joseph Ray Barrick	2. Date of Month March	Day Year 3. Time of Death 11:50 AM M
	Examir Funeral Director	er	4a. Facility Name (If not institution, give street and number) Calvert Memorial Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday) 7. Age (In yrs. last birthday)	4b. City, Town, or Location of Death Prince Frederick If Under 1 Year If Under 24 Hrs. Months Days Hours Min. March	Day, Yeer) Country)
	D	Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Lo Maryland Calvert Prince F 10e. Street and Number	ocation	23, 1927 Maryland 10d. Inside City Limits 1 Yes 2 No
-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show appropriate if item 27 is marked other than "natural", or Items 23a or 28a-f show appropriate or the Maryland of the first intermediate event. The Marked Examinar must be recified at once.	by Funerai	3 ☐ Widowed 4 🕅 Divorced If Yes, Give Year or Dates: 1947	20678 Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☐ No Specify:	Black, White, etc. Specify: White
Baltimore, Maryland 21215-0036	filed within 72 I Hygiene. other than "nal ent, the Madic	Be Completed	(Specify only highest grade completed) (Give life.	dent's Susai Occupation sind of work done during most of working DO NOT use retired) 18. Mother's Name (First, Mid	Paper Company Idle, Maiden Sumame)
, Marylan	and 2 should be ealth and Mental n 27 is marked o ier traumatic eve	ToB		Margaret Mary ing Address (Street and Number or Rural Route Num Howard Dr., Port Republ	mber, City or Town, State, Zip Code)
altimore,	permit. Pages 1 a Department of He Important: If item any injury or othe	7	20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 1 Donation 5 Other (Specify) Maryland	osition (Name of matory or other place) Vet. Cemetery 03-15-200 2. Name and Address of Facility Huntt Funeral Home	20c. Location - City or Town, State
	permi Depa Impo		23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	P.O. Box 156, Waldorf, I ter the mode of dying, such as cardiac or respirator	y arrest, Approximate Interval Between
8760,	/Medical Examiner	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of):	imphocytic Lew nt preumoni embranous Co Mellitus	'a
P.O. Box 6	that the death certific	by Physician/Med		□Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year
Records, P	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Completed by Pf	Part II. Other significant conditions contributing to death but not resulting in the under Science fic Candio V	108Cular disease 11	
Viital	ysician: is certifica director, p	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	26. Place of Death (Check on)	s 2 No 1 Yes 2 No
Division of	ittending Ph death. ctor: After th t the funeral	Certification; T	27. Manny of Death 1 Natural 5 Pending (Month, Day Year) 28b. Time of Injury 28b. Ti	f 28c. Injury at Work? M 1 Yes 2 No reet, factory, office 28f. Location	ne how injury occurred
ā	To the Hospital or At within 24 hours after or To the Funeral Direct completely filled in by	edical Cert	4 ☐ Homicide building, etc. (Specify) 29a. Certifier (Check only one) 11 ✓ Certifying Physician: To the best of my knowledge, deatt (2 ☐ Medical Examiner: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place, and due to the	Town, State) he cause(s) and manner as stated. ne, date and place, and due to the cause(s)
1	To th within To th comple	Me	29b. Signature and title of certifier Paul Sauci Mu 30. Name and a fress of person who completed sause of death (Item_23a) (Type,	29c. License number - D45092	29d. Date signed (<i>Month, Day, Year</i>) 3/6/2004
7	B D ² Sta Registr		30. Name and a fress of person who computed Jause of death (Item 23a) (Type, IIO HOSpifal Road Suik 31. Date filed (Month, Day, Year) MAR 0 8 2004 MAR 0 8 2004	303, Prince Tre	3/6/2004 eduick, MD 20678

			1- For State of Maryland Registrar	/ Depa <i>Cer</i>	irtment of F tificate of I	lealth a Death	nd Mer		iene 20	04	08913
	Physici	an	Decedent's Name (First, Middle, Last) Herman Lee Be	nton			-	Date of Deati Month	h Day	Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	IICOII	4b. Cily, Town, or	Location of		bruary	4c. County o		622 a M
			21600 Coltons Pt. Road		Avenu		ATT- T		St. N		
	Funeral Director		5. Social Security Number 251-98-6626 6. Sex 1 M 2 F 7. Age (In yrs. last)	Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Dece	Date of Birth (Month, Day, mber 2	20,1949	9. Birthpla Countr Sout!	Carolina
	land ow		Usual Residence of Decedent 10a. State 10b. County 10c. City, T	own or Lo	cation					100	d. Inside City Limits
	e-f sh	ctor	Maryland Charles Waldo	rf							1X Yes 2 □ No
	with th	Dire	10e. Street and Number		10f. Zip Code			10	og. Citizen of WI	nat Countr	ry?
	death ms 23	Funeral Director	11307 C Golden Eagle Place 11. Marital Status 12. Was Decedent Ever in U.S.	13. V	20603 Vas Decedent of H	ispanic Origi	in? (Specify	Yes or No-	USA 14. Race	- Americai	n Indian,
	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "neturel", or Items 23e or 28e-f show or other treumatic event, the Medical Exampler must be nutilised at	by	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No 1 Widowed 4 Divorced Year or Dates:		Yes, specify Cuba ☐ Yes 2 ☐ No	Specify:	Puerto Rica	ın, etc.)	1	White, et	
5	72 ho	eted	15. Decedent's Education (Specify only highest grade completed)	6a. Deced (Give	ent's Usual Occupa kind of work done of OO NOT use retired	ation during most of	of working	1	6b. Kind of Bus	iness/Indu	ustry
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y	d Men marke	T _o	Louis Benton 19a. Informant's Name/Relationship (Type, Print)	10h Mailio	g Address (Street a	Lilli			William		3- do l
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מ	permit. Departr Importe any inje		21. Signature of Funeral Service Licensee MO1 32.		Name and Address ams Fune:	,		A. Agu	asco,Ma:	rylan	nd
			23a. Part1. Enter the disease, or complications that caused the death. I shock, or heart failure. List only one cause on each line.	Do not ente	r the mode of dying	g, such as ca	ardiac or res	spiratory arre	st,	11	Approximate nterval Between Onset and Death
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	Examiner			000).							
	pe isi	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ce of):							
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Š	ding pl		IF FEMALE: 23c. If yes, outcome of pregnancy	,	<u> </u>				201.0		
	To the Hospitel or Attending Physicien: The law requires that the death certifulin 24 hours after death. To the Funerel Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 1 Live birth 2 Fetal de 4 Pregnant at time of death 9 Unknown	ath 3 🗆	Ectopic pregnancy Other (specify)				23d. Date Monti		yay Year
	s that the	by Ph	Part II. Dther significant conditions contributing to death but not resulting	g in the un	derlying cause give	on in Part I.		23e. Did toba	acco use contrib	ute to the	cause of death?
3	w requires been sign should be			_				1 🗌 Yes	No 3	Probab	oly 4 Unknown
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5	Physia r this c ral dire	: To		Outpatient	3□ DOA Othe	4 Nurs			oce 6 Other		at scene
5	nding ath. r: Afte e fune	ation	1 Natural 5 Pending (Month, Day Year) 2 Accident investigation 2 2 3 04	Injury	M 1□	?			CAN, E		50
2	or Attending Phys after death. Director: After this in by the funeral di	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home building, etc. (Specify)	- 19			(City or Town,	et and Number State)		
2	pitel cours af		29a. Certifier 1 Certifying Physician: To the best of my knowled		convered at the time	o data and					1 AMIS COM
	To the Hospitel or Attending Phwithin 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edicai	(Check only one) 2 Medical Examiner: On the basis of examination and manner stated.	and/or invi	estigation, in my op	pinion, death	occurred at	the time, dat	e and place, and	d due to th	ed. ne cause(s)
	To the To the Comp	M	29b. Signature and title of certifier	110	29c. License	number CME			d. Date signed (Februar		
T	20 1		30. Name and address of person who completed cause of death (Item 23	a) (Type, F	rint)						
	DOG		MARUSONTO B. KORIEU		111 Per	nn Str	reet,	Baltim	ore, Ma	rylan	d 21201
	Sta Registr		31. Date filed (Month, Day, Year) MAR 0 9 2004 32. Pogistrar's Signature	S	ale						

State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2004 **Physician** Month Shirley Virginia Beach March 4, 4:15 a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 9180 Southern Maryland Blvd. Owings Calvert If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year)
July 12,1946 **Funeral** Birthplace (State or Foreign Country) 1 ☐ M 2127 F Director 217-44-4129 57 Virginia Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits s 23a or 28a-f show ust be rutified at 1 ☐ Yes 2 No Director Maryland Calvert Owings 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 9180 Southern Maryland Blvd. 20736 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, f Health and Mental Hygiene. item 27 is marked other then "naturel", or Items other traumatic event, it e Medical Experiment Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: white 3 ☐ Widowed 4 X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 cashier retail grocery 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Hubert Thompson ၉ Goldie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michelle Beach, daughter 9180 So. Maryland Blvd., Owings, MD 20736 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of F Important: If ite any injury or ot once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) Washington National Mar.8,2004 Suitland, MD 21. Signature of Funeral Service Lice's e 22. Name and Address of Facility ellair Rausch Funeral Home, P.A., Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Physician reave /Medical Due to (or as a consequence of) Examiner Security is conditional if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of). Box 68760, Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. I been signed by the a should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an this certificate has al director, page 2 autopsy performed? 1 ☐ Yes 2 No After this certification funeral director, I Hospitel or Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 esidence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No investigation м 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Hame and address of person who completed cause of death (Item 23a) (Typa, Print) Bestyate Rd. Annapolis, Mu. 21401 31. Date filed (Month, Day, Year) 32. Registras Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 08915 For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dey Physician Arnold Edward Bryant February 28 2004 1518 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Carroll Hospital Center Westminster Carroll 7. Age (In yrs. last birthday) Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□F Days Director 217-38-8160 61 May 31 1942 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo MD Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1634 Hughes Shop Road natural, or items 23a 21158 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 25 Married 1 ☐ Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 No Specify. White Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than enry injury or other traumatic event, If a M ORGS. College (1-4or 5+) 12 Set-up Operator Black & Decker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Arnold Ernest Bryant Barbara Kramp ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Bryant/wife 1634 Hughes Shop Road Westminster, MD 21158 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 3/04/2004 1 Burial 2 Cremation 3 Removal from State Meadow Branch Cemetery ⁴ □ Donation 5 □ Other (Specify) Westminster, MD 21. Signature of Funeral Service Licensee Pritts Funeral Home and Chapel, P.A. 412 Washington Road Westminster, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician CVV) Months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to for as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Box 68760, Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 4□Pregnant at time of death Day Year 5 Other (specify) signed by the a d be detached f Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Be director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? After t 28d. Describe how injury occurred 1 Matural 5 Pending within 24 hours after death.

To the Funeral Director: A 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) WJL 00051924 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 Herbert P. Hencloson J. MA Da73 Manchester Rd Manchester MD 21102 31. Date filed (Month, Day, Year) 32. Registur's Signature State Registrar MAR 0 5 2004

ORIGINAL

DHMH 17 Rev 1/2001

			Please I	State of Manuford / Do		•	
			1_ For State		partment of Health and ertificate of Death		a. No. 2004 08916
			Registrar 1. Decedent's Name (First, Middle, Last)	<u> </u>	erinicate of Death	2. Date of Death	3. Time of Death
н	Physici		Catherine Marie B	ENEDICT		Month March 4	Day Year
3	/Medic Examin		4a. Facility Name (If not institution, give s	street and number)	4b. City, Town, or Location of Deat		4c. County of Death
1	Exami	٠.	403 S. Conocheagu	e Street	Williamsport		Washington
	Funeral		5. Social Security Number 6. Sex	144 007 5	Months Days Hours Min.	8. Date of Birth (Month, Day,)	(ear) 9. Birthplace (State or Foreign Country)
	Director		210-00-7000	71 Yrs.		March 22	2, 1932 Maryland
	land		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or	Location		10d. Inside City Limits
	Mary 1 sh	ţō	Maryland Washin	gton	/illiamsport		1X Yes 2 □ No
	r 28a	irec	10e. Street and Number		10f. Zip Code	100	g. Citizen of What Country?
	th wit	by Funeral Director	403 S. Conocheagu	e Street	21795		USA
	r dea	Jue	11. Marital Status	12. Was Decedent Ever in U.S. 1. Armed Forces?	 Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer 	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	s afte	Ž.	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☒ No Specify:		Specify: white
21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23e or 28e-f show ta Madical Exemirer must be notified at	ed b	15. Decedent's Educ	cation 16a De	cedent's Usual Occupation	16	Sb. Kind of Business/Industry
15	n "na	plet	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	ve kind of work done during most of wo. DO NOT use retired)	king	35. 11.13 3. 3.3.1.13.3.1.1
212	d with giene greene ar tha	Completed	10	0 hc	ousewife	h€	er own home
P	be filed tal Hygid d other event, II	Be (17. Father's Name (First, Middle, Last)			ne (First, Middle, Ma	uiden Surname)
y la	2 should be filled withir and Mental Hygiene. is marked other than aumatic event, Ite M	2	John Churchey			e Lewis	
Maryland	2 sh and is m raum		19a. Informant's Name/Relationship (Ty) Kimberly Farrar -		uiling Address (Street and Number or Ru BS. Conocheague S		•
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at ance.		20a. Method of Disposition	20b. Place of Dis	position (Name of		Oc. Location - City or Town, State
Baltimore,	Pages nent of it int: if it		1 ☑Burial 2 ☐ Cremation 3 ☐ Ri 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	rematory or other place) 11 Cemetery 3/9		gerstown, Maryland
Ħ	permit. Pag Department Important: I any injury o		21. Signature of Furreral Service License		2. Name and Address of Facility		FUNERAL HOME
B	permit. Departimport any inj		15 CATI.	n// /umico	415 E. Wilson Blvd		
			23a. Part. Enter the disease, or complications, or heart failure. List only on	cations that caused the death. Do not e	enter the mode of dying, such as cardiac	or respiratory arres	Interval Between
	Priysician		Immediate Cause (Final disease or condition	lu	na can	CON	Onset and Death
1	/Medical Examiner		resulting in death)	Due to (or as a consequence of):	0		JAHO HIL
	Lammer	_	Sequentially list conditions, b	. Due to (or as a consequence of):			
	ted nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	bue to (or as a consequence or).			
Ć,	e be executed sician and e burial-transit	Examiner	resulting in death) Last	Due to (or as a consequence of):			
760,	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	cai					
89	death certificate t attending physicate to a second of the tector of the	Physician/Medi	IF FEMALE:				
Вох	ath ce ttendi or use	lan/	23b. Was decedent pregnant in the past 12 months?		B Ectopic pregnancy		23d. Date of delivery Month Day Year
-	that the de hed by the a detached f	ysic	1 ☐ Yes 2 No 9 ☐ Unknown	4 Pregnant at time of death 9 Unknown	5 Other (specify)		
P.0	that the ed by detac	h h	Part II. Other significant conditions con	tributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	cco use contribute to the cause of death?
ds	puires tha n signed ald be del	d by	emnhu	De mor.		1 □ Yes	2 □ No 3 Probably 4 □Unknown
2	s been signature	olete				24a. Was an	24b. Were autopsy findings available prior to completion of cause of
æ	The la	Completed				autopsy performe 1 ☐ Yes 2	d2 death? No 1 Yes 2 No
of Vital Records,	ysician: The lav is certificate has director, page 2 :	Bec	25. Was case referred to medical examiner?			th (Check only one)	
>	Physician: rthis certifica ral director, I	2	1 ☐ Yes 2 Z No	ospital: 1 ☐ Inpatient 2 ☐ ER/Outpat			ce 6 □Other (Specify)
	Ilng P	io ii	27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Injury 28b. Time (Month, Day Year) Injury		28d. Describe how	injury occurred
Division	death death ctor: y the	ficat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At home, farm,		28f. Location (Stree	et and Number or Rural Route Number,
Θ	after after Dire	Certification:	4 ☐ Homicide determined	building, etc. (Specify)		City or Town, S	State)
	To the Hospital or Attanding Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier 1 Certifying Phys	ician: To the best of my knowledge, de ner: On the basis of examination and/or	ath occurred at the time, date and place	, and due to the caus	se(s) and manner as stated.
	the Hi iin 24 the Fi	Medicai	one)	and manner stated.			
	To COT	2	29b. Signature and title of certifier		29c. License number	29d	Date signed (Month, Day, Year)
	\sim		Mud H	(auday,	MD D4641	3 N	1911 8, 900H
}	X		30. Name and address of person who con	mpleted cause of death (Item 23a) (Typ	e, Print)	Haden	HOUND AN DIYLLD
	Sta	te	B1. Date filed (Month, Pay, Year)	32. Registrar's Signature	VIII CI.	11200	MANIATE OF LAC
	Registr	- 1	MAR 09 20	104 Alberton St.	Sperker		

			1 - For State Registrar	State of M	aryland / Depa <i>Ce</i>	artment of He rtificate of D	ealth and M Death	lental Hygid	ene 2004	08917
	Physici /Medic		1. Decedent's Name (First, Middle, La Robert Lee	Bowers				2. Date of Death March 7	7,2004 Yeer	3. Time of Death 9:00 pm
	Examir		4a. Fecility Name (If not institution, giv 12943 Spickle	er Road		4b. City, Town, or L Clear	ocation of Death Spring,		4c. County of Death Washing	ton
	Funeral Director		5. Social Security Number 220-34-0640 6. S	ex 7.Ag DXM 2□F	90 (In yrs. last birthday) 66 Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Y Dec. 9, 1	(ear) 9. Birthp Cour 937 MD	elace (State or Foreign try)
	Maryland -f ehow	tor	Usuel Residence of Decedent 10a. State 10b. County MD Washir	ngton	10c. City, Town or Lo Clear S				1	0d. Inside City Limits 1 ☐ Yes 2 No
	h with the 3e or 28e	al Direc	10e. Street and Number 12943 Spickle	er Road		10f. Zip Code 217	22	10g	D. Citizen of What Cour	ntry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or items 23a or 28a-f show spiritury or other traumatic event, the Medical Examinative Indifficult and once.	Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 \ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates:	Ever in U.S. 13.	Was Decedent of His If Yes, specify Cuban, 1 Yes 2 XNo	panic Origin? (Spe , Mexican, Puerto i Specity:	ocify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Wh:	
21215-0036	within 72 ho ene. then "natur te Medical	ompleted	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12) 12th grade	ducation ide completed) College (1-4or to 1)	(Give	dent's Usual Occupati kind of work done du DO NOT use retired) ntrol Ro	ring most of worki	ng	Bb. Kind of Business/Inc Electric	
Maryland 2	uld be filed Aental Hygi rked other tic event, I	To Be Co	17. Father's Name (First, Middle, Last, Donald Bowers			-1	8. Mother's Name Amanda	(First, Middle, Ma	_	
, Mary	and 2 shoralth and h		19a. Informant's Name/Relationship (Sharon M. Boy						City or Town, State, Zip	
Baltimore,	Pages 1 ament of He ment of He ant: If item ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 1 ☐ Donation 5 ☐ Other (Specification)		20b. Place of Dispo cemetery, crea Greenlay	sition (Name of matory or other place) Vn Cemete	March ^D ery 200	/	c. Location - City or To Williams	
Balt	permit. Depart Import eny inj		21. Signature of Funeral Service Licer	Sie	I	Name and Address Conald Ec	dwin The	ompson lar Spri	Funeral H	ome, Inc 722
,	Pnysician /Medical		23a. Pert1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a chio	the deeth. Do not ent ne.	er the mode of dying,	such as cardiac o	r respiratory arrest	seue.	Approximate Interval Between Onset and Death
	Examiner	er	Sequentially list conditions,	b	a consequence of):			ď		
oʻ	icate be executed physician and s the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as	a consequence of);		······································			
68760,		edicai		. d						
.O. Box	w requires that the death certifi been signed by the attending should be detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetel death 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ry Day Year
rds, P.	The law requires that the ste has been signed by thoage 2 should be detache	ed by PI	Part II. Other significant conditions of	ontributing to death b	ut not resulting in the u	Hoesepla	in Part I.		cco use contribute to the	
Division of Vital Records,	The lar	Completed	reflex disease	0				24a. Was an autopsy performed	d? prior to con	osy findings available inpletion of cause of 2 No
f Vit	nysiclar nis certif i director	To Be	25. Was case referred to medical examiner? 1 ☐ Yes ②☑No	Hospital: 1 Inpatie	ent 2 ER/Outpatien	Other	26. Place of Death 4 ☐ Nursing Hor		e 6 Other (Specify)
o uo	and and and and and and and and and and	atlon:	27. Manner of Death F⊠Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Day	ry 28b. Time of Injury	Work?	it 2 os 2 ⊡No	8d. Describe how	injury occurred	
Divis	To the Hospitel or Attending Ph within 24 hours atter death. To the Funeral Director: After th completely filled in by the funeral	Certification;	3 ☐ Suicide 6 ☐ Could not by determined	28e. Place of Injubul	ury - At home, farm, str c. (Specify)	eet, factory, office	2	8f. Location (Stree City or Town, S	et and Number or Rural State)	Route Number,
	the Hospi in 24 hour the Funer pletely fill	Medical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best niner: On the basis of and manner sta	of my knowledge, death f examination and/or invated.	occurred at the time, restigation, in my opin	, date and place, a nion, death occurre	nd due to the caus d at the time, date	se(s) and manner as sta and place, and due to	ated. the cause(s)
)	Veith Com	Σ	29b. Signature and title of eartifler	R		29c. License n	ootb94	O 0	Date signed (Month, $B = 3 - 09 - 6$	Day, Year)
5	*		30. Name and address of person who	ompleted cause of d	eath (Item 23a) (Type.	Print)		Hager 54	sow Mi	521742
*	Sta Registr		31. Date filed (Month Day, Year)	32. Registra	ar's Signature	acretis.		U		

			For State Registrar	State of	Marylar	nd / Depa <i>Cei</i>	artment <i>tificate</i>	of H	ealth a Death	and M	lental Hy	giene ,	2004	08	918
	Physicia /Medica Examine	n al	1. Decedent's Name (First, Middle, I Anice Louise B 4a. Facility Name (If not institution, g	lankner	nber)		4b. City, T	own, or	Location o	f Death	2. Date of De Month March	Day 7,	Year 2004 ounty of Death	3. Time of 9:50	
	Funeral				7. Age (<i>In yr</i> s. 81	last birthday) Yrs.	BBO	ansb			8. Date of Bir (Month, Da Aug. 3,	h	lashing		or Foreign
	Director	-o	112-20-7113 Usual Residence of Decedent 10a. State 10b. County Md. Washir		10c. Cit	ty, Town or Lo					Aug. 2,	1922		10d. Inside C	
le B	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "netural", or items 23a or 28a-1 show or other treumatic event, the Medical Examinar must be notified at	rai Di	10e. Street and Number 141 S. Main St.	12. Was Dece	dent Ever in U		10f. Zip (217		jin? (Spe	ecify Yes or No		on of What Cou		
lankr	2 hours after of tenter of	ted by Fur	1 Never Married 2 Married 3 XWidowed 4 Divorced 15. Decedent's	If Yes, Give Year or Da Education	2 (X No ∍	16a. Deced	l □ Yes 2	No Occupa	Specify:			S	Black, White pecify: W	hite	
lnice L. Blankner Maryland 21215-0036	be filed within 7 tal Hygiene. ed other than "r	Be Completed by	(Specify only highest g Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Lat	College (1- 4	4or 5+)		kind of work DO NOT use Iomema	ker			(First, Middle,	Maiden Si	Hom umame)	e	
<i>Znice</i> Maryla⊓	nd 2 should be alth and Mental 27 Is marked or r treumatic eve	To	Rudolph J. Po 19a. Informant's Name/Relationship Sandra N. Young	(Type, Print)	er)				nd Numbe	r or Rura	Pearl	er, City or 7	Town, State, Zij	Code)	
lame: C Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: If item 27 is any injury or other tree once.		20a. Method of Disposition 1 Burial 2 Commation 3 Donation 5 Other (Spec	□Removal from S	20b. F	ithsbur		matc	ry ^V	ar.8	stown, ,2004	Smit	hsburg	,Md.	
Nat	Depa Depa Impo any is		23a. Part 1. Enter the disease, or co shock, or heart failure. List on	mplications that ca	used the deat	o Da	vis F	unei	al H	ome	12525 E Smithsb r respiratory ar	urg, №	ıry Ave 1d.2178	Approximat Interval Bet	e ween
8760,	Physician /Medical Examiner the prival-transit the prival-transit physician and physician and physician and physician and physician are privally physician and physician physic	edical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (c) Due to (c) Due to (c)		quence of): ERENTE quence of): CLER		3	EED	>				Onset and I	Death S
Box 6	ath certific	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		rth 2 ☐ Feta int at time of d	ıl death 3 🗆	Ectopic pred Other (spec					230	d. Date of delive	•	Year
ords, P.	n requires that the de been signed by the s should be detached t	2	Part II. Other significant conditions	contributing to dea							1 🗆 Y	′es 2□1		pably 4 💢	Jnknown
Ital Rec	ician: The lav certificate has rector, page 2		25. Was case referred to medical	417						of Death		sy med? 2 No	death?	psy findings ampletion of ca	avaliable ause of
Division of Vital Records, P.O.	utending Physici death. ctor: After this cei y the funeral direc	ertification; Io B	examiner? 1	28a. Date of (Month		ER/Outpatient 28b. Time of Injury		Other	4 X Nur	sing Hon 2	ne 5 □ Resid	lence 6		(y)	
Divis	To the Hospitel or Attent within 24 hours after death To the Funeral Director: completely filled in by the	ა ⊥	3 Suicide 6 Could not determine 6 determine 29a. Certifier 6 Certifying F	289. Place	g, etc. (Specil)				date and		8f. Location (S City or Tow	m, State)			ber,
	To the Hos within 24 ho To the Fun completely	Medical	(Check only one) 2 Medical Exit	aminer: On the bas	sis of examina	ttion and/or inv	estigation, in	n my opi License	nion, death	occurre	d at the time, o	date and place 29d. Date s	igned (Month,	Day, Year)	1
1	State Registra	e	Dr. Zafar Malik 31. Date filed (Month, Day, Year) MAR 08 2	20311	Lappan	s Road	Вос	nsb	oro,	MD	21740	(30	01) 432	-8470	

			For State Registrar	State	of Mar	yland / Depa Ce	artment of F rtificate of	lealth and Death	d Mental Hy	/giene Reg. No.	2004	08919
ľ	Physici	an	1. Decedent's Name (First, Midd Kristi Kaye						2. Date of De Month	Day	Yeer	3. Time of Death
	/Medio Examir		4a. Facility Name (If not institution		number)		4b. City, Town, o	r Location of De	March	4c. C	2004 ounty of Death	2:37 P. ^M
			302 Willow				Freder			F	rederi	ck
	Funeral Director		5. Social Security Number 215-84-8263	6. Sex 1 □ M 2√ F		(In yrs. last birthday) 39 Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi	rs. 8. Date of Bi (Month, D Aug.	^{rth} 28,196		place (State or Foreign http) ryland
	land ow		Usual Residence of Decedent 10a. State 10b. Count	у	1	Oc. City, Town or Lo	cation				1	10d. Inside City Limits
	a-f eh	ctor	Md. Frede	rick			Fre	derick				1 🏹 Yes 2 🗌 No
	vith th	Director	10e. Street and Number			· ·	10f. Zip Code			_	n of What Cour	ntry?
	ns 23s	Funeral	302 Willow A	IVE .	cedent Ev	er in U.S. 13	Was Decedent of H	21701	(Specify Yes or N		U.S.A. Race - Americ	can Indian
136	be filed within 72 hours after death with the Maryland Ital Hygiene. d other then "natural", or itams 23a or 28a-f ehow event, Ita Medical Examinar must be notified at	by Fun	1 Never Married 2 Ma 3 Widowed 4 Divorce	rried 1 Tyes	Forces? s X ∏ No Give		Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2🎇 No	Specify:	erto Rican, etc.)		Black, White,	etc.
2	72 hou	eted	15. Decede	nt's Education	4)	16a. Dece	dent's Usual Occup kind of work done of	ation	vorking	16b. Kind	of Business/In	dustry
21215-0036	within one.	Completed	Elementary/Secondary (0-12)		(1-4or 5+)	life.	DO NOT use retired) -	ioning		11	
	filed wi Hygien other th	Be Co	1.2 17. Father's Name (First, Middle	, Last)			нош	emaker 18. Mother's N	ame (First, Middle	, Maiden Su	Home	
/lan		To B	Roy E. Bake	r Jr.				Billie	e Jeanne	Mille	r	
Maryland	2 2 2 2		19a. Informant's Name/Relation				g Address (Street a					Code)
	1 and Health em 27 ther tr		John Spencer 20a. Method of Disposition	(Friend)		302 20b. Place of Dispo	Willow .	Ave. Fr	ederick,N		701 tion - City or To	Chata
Š	Pages nent of int: if it		1 ☐ Burial 2 ☒ Cremation		State	cometery, crem Smithsbur	natory or other plac	Mai	rch 5,		hsburg,	
Baltimore,	permit. Pages Department of Important: If Ii any injury or o	(21. Signature of uneral Service		3		. Name and Addres		004 12525 H		ry Ave.	
n	88 = 8		Pennis	V. T	ave		vis Fune				d. 2178	13
2	Physician		23a. Part1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	or complications that tonly one cause or	each line.	e death. Do not ent				rrest,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due t		consequence of):						
My		ner	Sequentially list conditions, if any, leeding to immediate	b. — Due to	o (or as a c	consequence of):						
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ρĊ,	icate be executed physician and s the burial-transit	a E	resulting in death) Last	Due to	o (or as a c	consequence of):						
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XOD	death certifi e attending I id for use as	an/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, o			Ectopic pregnancy			23d	I. Date of delive	ry
L	0 0 0	Physician/M	in the past 12 months? 1 ☐ Yes 2 € No 9 ☐ Unknown		gnant at tim		Other (specify)		· · · · · · · · · · · · · · · · · · ·		Month	Day Year
ŗ	law requires that the di as been signed by the 2 should be detached	by Ph	Part II. Other significant condit	ons contributing to	death but r	not resulting in the ur	derlying cause give	n in Part I.	23e. Did t	obacco use	contribute to th	e cause of death?
ecords,	equires en sign ould be							·	10	res 2 1	lo 3 Proba	ably 4 Unknown
မင္မ	8 8 6	Completed							24a. Was		4b. Were autop	osy findings available inpletion of cause of
T m	ate pag								perfo 1 ☐ Yes	rmed?	death? 1 ☐ Yes	
VItal	Attending Physician: The death. sctor: After this certificate by the funeral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital:	Inpatient	2 ER/Outpatien	2□ po∧ Othe		ath (Check only o			-
0	ding Phy h. After this funeral d	\vdash	27. Manner of Death	28a. Date	of Injury onth, Day Y	28b. Time of	28c. Injury Work	at 2	Home 5 X Pesid 28d. Describe 1)
SIOIS	Attendir ar death. rector: Af by the fur	catic	1 Natural 5 Pendi 2 Accident invest 3 Suicide 6 Could	igation	, <u></u> y	out, injury		es 2□No				
DIVISION	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	4 Homicide determ	ninged 280, Place	e of Injury ding, etc. (- At home, farm, stre Specify)	et, factory, office		28f. Location (S City or Tov	Street and N vn, State)	umber or Rural	Route Number,
	To the Hospi within 24 hou To the Funer completely fill	edical	29a. Certifier 1 Certifyi (Check only one) 2 Medical	Examiner: On the	ne best of n basis of ex nner stated	ny knowledge, death amination and/or inv d.	occurred at the tim estigation, in my op	e, date and place inion, death occ	ce, and due to the curred at the time,	cause(s) and date and pla	d manner as sta ice, and due to	ated. the cause(s)
	Withir To the comp	×	29b. Signature and fittle of certific	11882	A		29c. License			29d. Date si	igned (Month, D	Day, Year)
	٨		Munl	10 Com	te 1	N	03	1761		3/3	104	
-	'H'		30. Name and address of person	who completed car	use of deat	h (Item 23a) (Type, I	Print) EVENTU	ST	FRENER	ICH	MA	21701
	Sta	te	30. Name and address of person RMANM, 04 31. Date filed (Month, Day, Year, MAR	32.	Registrar's	Signature	1. 1.			,	لعره	
	Registr	ar	#AR €	0 2004	TENCE	~ B. D.	our					

	1085		1 - For State Registrar	State of Ma	rylar				lealth a			Reg. No	2001	0892) (
	Physici /Medi Examir	cal	Decedent's Name (First, Middle, Nevin E. B1 i Aa. Facility Name (If not institution, g	ckenstaff	Sr		4b. City	, Town, or	Location o	of Death	2. Date of Dea Month March	Da 4.	y Year 2004 . County of Deatl	3. Time of Death	М
	Funeral Director		Frederick Memor 5. Social Security Number 6 216-22-8446 Usual Residence of Decedent			last birthday) Yrs.		ederic er 1 Year Days	ok If Under: Hours	24 Hrs. Min.	8. Date of Birt (Month, Da) Feb. 10,	h y, Yea <i>r)</i>	rederic ^{9. Birth} Mary	nplace (State or Fore	ign
	h the Maryland ir 28e-f show	Irector	10a. State 10b. County MD Frederic 10e. Street and Number			y,TownorLo	.e	ip Code				10g. Cit	izen of What Co	10d. Inside City Limi 1 ☐ Yes 2 🕱N	
9800	be filed within 72 hours after death with the Maryland hat Hygiene. Ind Hygiene. Independent than "natural", or fleme 23a or 28e-1 show event, the Medical Examiner, usal be notified at	d by Funeral Director	12109 Loy Wolf 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 □ Yes 2 1 No If Yes, Give Year or Dates:		, ,	I □ Yes	2 ∑ No	spanic Orion, Mexican	gin? (Spe i, Puerto I	cify Yes or No- Rican, etc.)			hite	
Maryland 21215-0036	e filed within 72 I al Hygiene. I other than "nati vent, Liv Medici	e Completed	15. Decedent's (Specify only highest of Specify only highest only highes	college (1-4or 5+)	16a. Deced (Give life. L	kind of w DO NOT	ork done a use retired,	luring most		(First, Middle,	Iro	7 7	•	
Marylan	nd 2 should be Ith and Mental 27 is marked o treumatic eve	To B	Edward Blaine 19a. Informant's Name/Relationship Donna V. Draper		ff				ind Numbe	or or Rura		r, City o	r Town, State, Z		
Baltimore,	permit. Pages 1 and 2 should b Department of Health and Menta Importent: If item 27 is marked any injury or other treumatic e <u>once.</u>		20a. Method of Disposition 1 \(\mathbb{R}\) Burial 2 \(\mathbb{Cremation} \) 3 \(\mathbb{O}\) Donation 5 \(\mathbb{O}\) Other (Special Service Lice). Signature of Eurosal Service Lice	cify)	l .	Place of Disposemetery, cremitary	sition (Na natory or Luth	ime of other place eran	9)	o 3/8/2	2004 ;	20c. Lo S mit	cation - City or 1 hsbure,	own, State	
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8760,	death certificate be executed by Sician /Medical e attending physicien and deformed as the burial-transit	Ical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a control of the co	consequence	uence of):	190,								
P.O. Box 68	death certific e attending p ed for use as	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1□Live birth 2 4□Pregnant at tir 9□ Unknown	Fetal	death 3	Ectopic p Other (s	oregnancy oecify)				2	23d. Date of deliv Month	rery Day Year	
Records, P.	Physicien: The law requires that the this certificate has been signed by the tal director, page 2 should be detach	ρ	Part II. Other significant conditions	contributing to death but	not resu	ulting in the un	derlying	cause give	n in Part I.		23e. Did to			the cause of death?	n
ital Rec	Physicien: The law this certificate has b al director, page 2 s.	Be Completed	25. Was case referred to medical						26. Place	of Death	24a. Was a autops perform 1 Yes	med? 2 No	24b. Were autoprior to codeath?	opsy findings available impletion of cause of 2 No	е
Division of Vital	Jing Afte fune	Certification; To E	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigate			ER/Outpatient 28b. Time of Injury		Othe 28c. Injury Work	r: 4 □ Nur at	rsing Hom		ence 6	S	fy)	
Dİ	spitel		3 Suicide 6 Could not determine 29a. Certifier 1 Certifying F	d 28e. Place of injury building, etc.	my knov	v) wledge, death	occurred	at the time	e, date and	1 place a	City or Town	n, State,	and manner as s	al Route Number,	
ì	within 2 To the comple	Medical	(Check only one) 2 ☐ Medical Ēxi 29b. Signature and title of certifier	and manner state	kamınat	tion and/or inv	estigation	c. License	inion, death	h occurre	d at the time, d	ate and	place, and due to signed (Month,	o the cause(s)	
3	Sta		30. Name and address of person who will be a second of the	32. Registrar's		W	Print	late	د د.				1		
	Registr	ar	MARUC	ZUU4 Zace	the same	13.	suda	1							

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			For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment of H rtificate of L			ane∠UU↓	08921
	Dhomini		1. Decedent's Name (First, Middle,					2. Date of Death Month	Day Year	3. Time of Death
	Physici /Medic				use	1		Mar 6	2004	4:12A M
	Examin	er	4a. Facility Name (If not institution,				Location of Death		4c. County of Death	
	Funeral		Civista Medi	S. Sex 37 7. Ag	Γ e (In yrs. last birthday,	LaPlat If Under 1 Year	a If Under 24 Hrs.	8. Date of Birth	Charles 9. Birthy	place (State or Foreign
	Funeral Director		214-28-4191	1□ M 2XF	93 Yrs.	Months Days	Hours Febru	8. Date of Birth (Month, Day, Y uary 19	,1911 °i	place (State or Foreign ntry) Maryland
	yland now		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	a-f sh	ctor	MD Char	les	Nanje	moy				1 ☐ Yes 2 No
	or 28	Dire	10e. Street and Number	T		10f. Zip Code 20662)	100	g. Citizen of What Cou USA	ntry?
	s 23a	eral	3265 Grayton	12. Was Decedent	Ever in U.S. 13			cify Yes or No-	14. Race - Ameri	can Indian.
Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after deeth with the Maryland at of Health and Mental Hyglene. If Item 27 is marked other than "naturel; or Items 23s or 28s-f show or other traumatic avent, the Medical Exacili writinal to incillial at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Marrie 3 □ Widowed 4 □ Divorced	Armed Forces?	No	If Yes, specify Cuba 1 ☐ Yes 2 X No	ispanic Origin? (Spe in, Mexican, Puerto I Specify:	Rican, etc.)	Black, White,	
5-0	72 ho	eted	15. Decedent's (Specify only highest	Education grade completed)	16a. Dece (Give	dent's Usual Occup	ation during most of workii f)	ng 16	6b. Kind of Business/In	dustry
2	ne.	Completed	Elementary/Secondary (0-12)	College (1-4or	5+) /ife.	Homema			Home	ے
2	2 should be filed within and Mental Hygiene. is marked other than " aumatic avent, It's Me		17. Father's Name (First, Middle, L.	ast)		Homemo	18. Mother's Name	(First, Middle, Ma		-
an	should be nd Mental marked o	To Be	Richard Bowie				Nora E.	Posey		
ary	shou and M amar urmat	-	19a. Informant's Name/Relationshi	р (Турө, Print)	19b. Mail	ing Address (Street	and Number or Rura	l Route Number, (City or Town, State, Zip	Code)
	and 2 ealth a m 27 in		William Crou	ıse/Son					oy, MD. 20	
Baltimore,	permit. Pages 1 and Department of Health Important: If Item 27 any injury or other tr once.		20a. Method of Disposition 1 ØBurial 2 □ Cremation 1 4 □ Donation 5 □ Other (Sp.	ecify)	Nanjem	matory or other place			anjemoy,	
Balt	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service L	Echut	1	P.O. BC	$0X_{567}$ L	A PLATA	L HOME,P	
			23a. Part1. Enter the disease, or co shock, or heart failure. List o	omplications that cause nly one cause on each l	d the death. Do not er ine.	iter the mode of dyin	ig, such as cardiac o	r respiratory arres	it,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	-a. COM	* EFSTI	JE HE	ART	FAILU	RE	Onsor and boats
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):	,				
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			IF FEMALE:	60- 14						
O. Box	law requires that the death certif as been signed by the attending 2 should be detached for use a:	Physiclan/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date of deliv Month	ery Day Year
Q	that ned by deta	by Ph	Part II. Other significant condition	s contributing to death	out not resulting in the	underlying cause giv	en in Part I.	23e. Did toba	acco use contribute to t	he cause of death?
rds	w require: been sign should by	ed b						1 ☐ Yes	2 □No 3 □ Proi	bably 4 □Unknown
of Vital Records,	aw requas been 2 should	Completed						24a. Was an autopsy	prior to co	opsy findings available
H	The ate h page	E O						performe 1 ☐ Yes 25	ed? death? √No 1 ☐ Yes	2 No
/ita	Physicien: The law this certificate has t al director, page 2 s	Be	25. Was case referred to medical examiner?	Hospital:		ort 3CLDOA Oth	26. Place of Death			
of	Phy at a	.To	1 Yes 2 No	28a. Die of Inj		HIL SUIDON	4 🗆 Hursing Ho	me 5 🗍 Residen 28d. Describe how	ce 6 Other (Special of the control o	<i>(y)</i>
On	fing After fune	tlon	1 Natural 5 Pending 2 Accident investig	(Month, D	ay Year) Injury	Wor	k? Yes 2 □ No			
Division	of or Attending after death. Director: Attending in by the fune	ertifica	3 Suicide 6 Could not determine	ot be 28e. Place of Ir	jury - At home, farm, s tc. <i>(Specify)</i>	treet, lactory, office		28I. Location (Stre City or Town,	eet and Number or Run State)	al Route Number,
	To the Hospitel or Attending i within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical Certification:		Physician: To the best xaminer: On the basis of and manner s	of examination and/or i					
	To th withir To th comp	Me	29b. Signature and title of certifier			29c. Licens	e number	290	d. Date signed (Month,	Day, Year)
)			* Kouse	17 Mell	~	02	J-352		3/6/0	7
(0 5		30. Name and address of person v	no completed cause of	death (Item 23a) (Type	Print)	MI	0641	<u> </u>	
	כמ		31. Date liled (Month, Day, Year)	32 Paris	rar's Signature	LUE	1 1	2046)	
	St: Regist	ate rar	31. Date liled (Month, Day, Year) MAR 0 9		use the	South &				

State of Maryland / Department of Health and Mental Hygiene 2004 08922 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Marlene Denise Coward 2004 5:23 March /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Prince George's Southern Maryland Hospital Clinton If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□M 2ਊF Months Director 47 18, 1957 578-84-8562 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show event, the Medical Examiner must be notified at 11 Yes 2 □ No Director St. Leonard MD Calvert 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò or Items 23a 20685 2050 Peace Court Funeral USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 21 No Specify: þ Specify: 3 Widowed 4 Divorced natural', Year or Dates: Black. Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4or 5+) 9 Secretary U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be fil Department of Health and Mental H Important: if item 27 is marked ott any injury or other traumattic even 2008: and Mental Horace Gulledge Mildred Settle 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1909 Belle Haven Dr. #104, Landover, MD 20785 Charlene Flood/ Sister Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/9/04 Alexandria, VA Metropolitan Crem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Raymond-Wood Funeral Home, P.A. PO Box 430, Dunkirk, MD 20754 ow 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician ACUTE MYOCARDIAL INFARCTION /Medical resulting in death) Due to (or as a consequence of): Examiner ORONARY ARTERY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Examiner sician a Due to (or as a consequence of): ivision of Vital Records, P.O. Box 68760, Physician/Medical phys. as for use a IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) ed by the a detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ HYPERTENSION 2 No 1 🗌 Yes 3 Probably 4 Unknown 2 should Be Completed been END STAGE RENAL DISEASE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed page certificate DIABETES 1 Yes 2 No 1 ☐ Yes 2 ☐ No funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 P/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending after death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - Athome, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 5 within 24 hours a To the Funeral C completely filled i To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D40324 MARCH 2, 2004 30. Name any address of person who completed cause of death (Item 23a) (Type, Print) JODRIE, MO, 7503 SURRATTS ROAD, CLINTON, MARYLAND 31. Date filed (Month, Day, Year) 32. Registres Signature State MAR 0 4 2004 Registrar BREUR S.

			For State Registrar	State of Maryla		rtment of H tificate of L			ene 1. No. 20 (08923
	Physici /Medic		Decedent's Name (First, Middle, Last JAMES		ION, JR.			2. Date of Death Month		3. Time of Death ear 2004 1426 M
	Examir		4a. Facility Name (If not institution, give PENINSUIA REGIONA	street and number)	CONTY		Location of Death		4c. County of	Death CO
6	Funeral Director		417 74 2211	7. Age (In yi	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Marth, Day, 1		Birthplace (State or Foreign Country) PRINCESS ANNE
	Maryland f show	JO.	Usual Residence of Decedent 10a. State 10b. County MD. WICOMICO	_	City, Town or Loc SAL ISBUR					10d. Inside City Limits 1 1 You 2 □ No
	ath with the Marylan 23a or 28e-f show	i Director	10e. Street and Number 605 EAST CHU	IRCH ST.		10f. Zip Code		100	g. Citizen of Wha	at Country?
و	0 2 E	by Funeral	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give	If	21804 /as Decedent of Hill Yes, specify Cubar	spanic Origin? (Spe n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	Black, \	American Indian, White, etc.
کر 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or tem any injury or other treumatic event, I'm Medical Evantral once.	leted by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Edu (Specify only highest grad	Year or Dates:	16a. Deced	ent's Usual Occupa	Specify: tion uring most of worki	ng 16	Specify: A	AFRO-AMERICAN ness/Industry
الادر d 212	filed withir Hygiene. ther than	Completed	Elementary/Secondary (0-12) 12th 17. Father's Name (First, Middle, Last)	College (1-4or 5+)	LABO		18. Mother's Name	1A		PAVING CO.
CANNO.	should be id Mental marked o matic eve	To Be		ARD CANNON, S		Address /Street a	nd Number or Rura	AMELIA V	VATERS	to Tie Code)
\(\) \(\)	s 1 and 2 s f Health ar frem 27 ls other treu		JOYCE D. CANNON 20a. Method of Disposition	/WIFE	605 Place of Dispos	EAST CHUP	RCH STREE	T: SALISE	BURY, MD	21804
J.Am.	nit. Pages vartment of corrent: If injury or	1	1 🂢 Burial 2 ☐ Cremation 3 ☐ F *4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens		JOHN WE	atory or other place SLEY CEM Name and Address	2-28	-04 de		and road P.ANN
() W	permi Depa Impo any ii		23a. Part1. Enter the disease, or compl shock, onheart failure. List only or	ications that caused the de	1	213 JERSE	Y ROAD:	SALISBURY	, MD. 2	21801 Approximate
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consi	Sesti	re Heo	of fa	lure		Interval Between Onset and Death
D.S.	rcate be executed my physician and my sthe burial-transit	ai Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	equence of					
P.O. Box 687	Attending Physicien: The law requires that the death certificate robath. rdeath. ector: After this certificate has been signed by the attending physy the funeral director, page 2 should be delached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	3c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	tal death 3 □ E	Ectopic pregnancy Other (specify)		7	23d. Date of Month	f delivery Day Year
rds, P	w requires that been signed b should be dete	by	Part II. Other significant conditions cor	ntributing to death but not re	esulting in the und	derlying cause give	n in Part I.	23e. Did tobac	\ /	te to the cause of death? Probably 4 □Unknown
Division of Vital Records,	iicien: The law requ certificate has been rector, page 2 shouk	Completed						24a. Was an autopsy performed	d? prior	e autopsy findings available to completion of cause of h? Yes 2 \sumbox No
, Vit	ysicien: is certific director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	lospital: 1 Inpatient 2	☐ ER/Outpatient	3□ DOA Other	26. Place of Death	(Check only one)	« Поть » /«	C-celf 1
ion of	utending Phydeath. ctor: After thi y the funeral	ation: 1	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work		8d. Describe how		<i>ървспу)</i>
Divis	tel or Atters after de el Directo	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm, stree cify)	et, factory, office	2	8f. Location (Stree City or Town, S	t and Number or tate)	r Rural Route Number,
	To the Hospitel or Attenwithin 24 hours after deall To the Funerel Director: completely filled in by the	Medical	29a. Certifier 1 Certifying Physical Check only 2 Medicel Exernity	sician: To the best of my kr ner: On the basis of examin and manner stated.	nowledge, death on ation and/or investigation	occurred at the time estigation, in my opi	, date and place, a nion, death occurre	nd due to the caus d at the time, date	e(s) and manner and place, and	r as stated. due to the cause(s)
	To Youth	2	29b. Signature and title of certifier	_		29c. License	number 55.658	29d.	Date signed (Me	Jooth, Day, Year)
4Da			30. Name and address of person who co	MD. 400	enstern3	rint)	TUR SAlis	burn Me	e a18	03
	Sta Registr		31. Date filed (Month, Day, Year) MAR 0 1 20	32. Registrar's Sign		Spark		0		

			1 - State Registrar	State of M	/laryland / D	epartment d Certificate	of Health an of Death	d Mental H	ygiene 2	2004	08924
			Decedent's Name (First, Middle, Last)				2. Date of D	eath		3. Time of Death
	Physici		MARGARE	T ANN C	COATES			Month FEB.	Day 27	Year 11/4	0245 M
1	/Medic Examir		4a. Facility Name (If not institution, give			4b. City, Tox	vn, or Location of E		4c. Co	unty of Death	1 0247
	LXUIIII		Atlantic General	l Hospita	al	BERL	TN			WORCES	TED
	Funeral		5. Social Security Number 6. Se	x 7. A	Age (In yrs. last birth	day) If Under 1 Y	ear If Under 24	Hrs. 8. Date of B	lirth	9. Birtho	place (State or Foreign
	Director		577 – 32 – 8043	∃M 2□F	76 Y	rs. Months D	ays Hours	Min. (Menth, L	Zey Year) Zey Zey	SEAT	PLEASANT
	ъ		Usual Residence of Decedent								
	how	_	10a. State 10b. County		10c. City, Town					1	10d. Inside City Limits
10	a-fs	cto	MD. WICOMIC	;U	WILLAR	RD					1V Yes 2 No
X	# 50 a	Director	10e. Street and Number			10f. Zip Co	de		10g. Citizer	of What Coul	ntry?
1	72 hours after death with the Maryland natural', or Items 23a or 28a-f show dical Examiner must be notified a		7353 CANAL	STREET			21874		l	JSA	
	items items	Funeral	11. Marital Status	12. Was Deceden Armed Forces	nt Ever in U.S.	13. Was Decedent	of Hispanic Origin Cuban, Mexican, F	? (Specify Yes or Nuerto Rican, etc.)	No- 14.	Race - Americ Black, White,	
9	or it	匠	1) Never Married 2 Married	1 ☐ Yes 2X If Yes, Give		1 ☐ Yes 2				ecify: WHI	
0245 21215-0036	ours Fal',	d by	3 Widowed 4 Divorced	Year or Dates	s:						
5.6	72 h 'natu	Completed	15. Decedent's Edu (Specify only highest grad		16a. C	Decedent's Usual C 'Give kind of work o life. DO NOT use r	ccupation lone during most of	working	16b. Kind	of Business/In	dustry
245	nithin nan nan	du	Elementary/Secondary (0-12)	College (1-4or	r 5+)		etired)				
	filed with Hygiene other than		9th			ABORER	40.14-15-4-	Name (First Midd		SEWORK_	
26 04 Ind	be filed within 72 hours after ital Hygiene. Id other than "natural", or Ite event, I'm Wedfoxl Eraning	Be	17. Father's Name (First, Middle, Last)	CONTEC			18. Mothers	Name (First, Middle			
26/1926 27/2004 Maryland	d 2 should be filed within the and Mental Hygiene. 7 Is marked other than traumatic event, the M	은	T T T T T T T T T T T T T T T T T T T	. COATES					E LAMBE		
s /			19a. Informant's Name/Relationship (T) DORIS JEAN DOVE					or Rural Route Num			Code)
				L/ DAUGHT				WILLARD,			State
Dog 9/2 DoD 2/2 Baltimore,			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ I	Removal from Stat	comotone	Disposition (Name of crematory or othe	r place)	Date	20c. Locat	ion - City or To	own, State ITCDHDV MD
E.ag	permit. Page Department Important: If any injury o		*4 □Donation 5 □ Other (Specify,			URY CREM		-28-04	SNOWH]		LISBURY, MD
Do. Do Balt	permit. Departr Importa		21. Signature of Funeral Service Licens	99			ddress of Facility	JOLLEY N			
D /- E	205 20		JArula D	tolle	ef			, SALISBU		2180	1
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that cause ne cause on each	ed the death. Do no line.	ot enter the mode o	f dying, such as ca	rdiac or respiratory	arrest,		Approximate Interval Between
	Physician	0	Immediate Cause (Final disease or condition		25,5						Onset and Death
$\overline{}$	/Medical		resulting in death)	a	as a consequence of):	-				
	Examiner		Sequentially list conditions	PER	EVERTE	D TOXI	C ME	GACOL	S		
		ner	Sequentially list conditions, I any, I adding to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events	Sua to (or a	as a consequence of	ŋ·					
43	cuted od ransi	Examin	Cause (Disease or injury that initiated events	c							
_	an ar		resulting in death) Last	Due to (or a	as a consequence of	·):					
- PO 8760,	cate be executed physician and the burial-transit	dlcai		d							
<i>K</i> 9		Med	IE EE WALE							-	
7 - 3. Box	eath certific attending p	Physician/Me	23b. was decedent pregnant	23c. If yes, outcom 1 ☐ Live birth	ne of pregnancy 2 Fetel death	3 Ectopic pregr	nancy		23d	. Date of delive	,
	deat e att	Sicient	in the past 12 months? 1 Yes 2 No		at time of death	5 ☐ Other (special				Month	Day Year
-9% P.O.	t the de by the a tached t	hys	9 Unknown	9 Onknown							
10	The law requires that the death certifi ate has been signed by the attending page 2 should be detached for use as	by	Part II. Other significant conditions co	ntributing to death	but not resulting in t	the underlying caus	e given in Part I.	23e. Did	tobacco use		he cause of death?
Les L	w require been signal		COPD, C	4				_ 10	Yes 2 1	io 3⊡Prob	bably 4 ⊡Unknown
60	s been	pet						24a. Wa		4b. Were auto	psy findings available
oate tal Rec	The law te has age 2	ompleted						per	opsy formed? 2 No	death?	mpletion of cause of
Co _C	ician: The certificate h rector, page	O	25. Was case referred to medical				26 Place of	Death (Check only		1 1 1 1 1 1 1 1	2010
○ ¥	sicis	0 0	avaminar?	Hospital: 1 Umpa	r itient 2 ☐ ER/Outg	patient 3 DOA	Othor	ng Home 5 Re		Other (Specif	(v)
+ 5	Phy or this eral o		27. Mann Death	28a. Date of In	1	and the second second	Injury at Work?	28d. Describe			77
augale	ding th. tune	ertification;	1 ✓ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, L	Day Year) Inj	ury M	Work? 1 ☐ Yes 2 ☐ No				
go isi	Atter dea ctor	fica	3 Suicide 6 Could not be	200. Flace of 1	Injury - At home, farr	n, street, factory, of	fice			lumber or Rura	al Route Number,
Magale	after Dire	erti	4 Homicide	building,	etc. (Specify)			City or T	own, State)		
8	spita nours neral	a C			st of my knowledge,						
	ne Ho n 24 h ne Fu iletely	edical	(Check only 2 Medicel Exam one)	iner: On the basis and manner:	of examination and stated.	or investigation, in	my opinion, death	occurred at the time	e, date and pla	ice, and due to	the cause(s)
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifies completely filled in by the funeral director, f	ž	29b. Signature and title of certifier			29c. L	cense number		29d. Date s	igned (Month,	Day, Year)
			1/ hor	. M	()	100	059975	S	2/	27/04	+
			30. Name and address of person who c	ompleted cause of	I death (Item 23a) (T	ype, Print)					
120			THUAN DANG	ATLAR	Tre Su	RG. 2	3 BROAL	55.	BERL	w, m	021811
	Sta	ate	31. Date liled (Month, Day, Year)		strar's Signature	4 100	1.1			-	
	Regist	rar	MAK U I ZU	104	1	apo					

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Phydician Day John Philip Coblentz, Sr. March 2004 /Medical 1700 AM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Milestone Garden Apt. Bldg. 3 Apt. H Williamsport Maryland If Under 1 Year 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**⊠** M 2□ F Days 93 Yrs. Director Nov. 28 1910 Maryland 10-9000 Pages 1 end 2 should be filed within 72 hours after deeth with the Maryland 10b. County 10c. City, Town or Location Show 10d. Inside City Limits r than "netural", or items 23a or 28a-f shov the Medical Examiner must be notified at 1 ☐ Yes 2/CNo Director Maryland Washington Williamsport 10e. Street and Number 10f. Zip Čode 10g. Citizen of What Country? 21795 Funeral U.S.A. Milestone Garden Apt. Bldg. 3

Marital Status 12. Was Decedent Ever in U.S.

Armed Forces? 3 Apt. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 3altimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify. Specify: White ģ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Engineer Power Company t of Health and Mental Hygi If item 27 is marked other or other treumatic event, I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Oscar B. Coblentz ပ Margaret L. Pontius 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lynne C. Gruber/Daughter 10821 Archer Lane Williamsport Maryland 21795 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any Injury or once. Mar. 7,04 Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. N. Hagerstown, Maryland 2174 23a. Part1. Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 600 Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) NIC Examiner Due to (or as a consequence of) Examiner 2003 or Attending Physicien: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last attending physician and I for use as the buriel-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 → Yes 2 □ No 3 □ Probably 4 □ Unknown þ cate has been sig Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No certificate 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ို 1 Yes 2 →No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After t 1 Natural 5 Pending investigation death. 1 Yes 2 No the Funeral Director: / 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours e To the Funerel C the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3623 and address of person who completed cause of death (Item 23a) (Type, Print) ms 1410 mec 32. Registrar's Signature State

Registrar

State of Maryland / Department of Health and Mental Hygiene ? 1 1 - For State Registrar Certificate of Death Reg. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 00360 M James JUSEPH 2004 march /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Washington County Hospital Hagerstown If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Jan. 22, 1931 9. Birthplace (State or Foreign 6. Sex 1 X M 2 ☐ F 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours 73 Maryland 214-28-7348 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location with the Maryland 10a State 10b. County 28e-f show the Medical Examiner must be notified at 1X Yes 2 No Completed by Funeral Director Hagerstown Maryland Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ö USA 21740 33 Richmond Street or itema 23a Pages 1 and 2 should be filed within 72 hours atter death vanel of Health and Mental Hygenes.
ansi: if leave 72 is marked other than "natural", or itema 23a ury or other freumatic event, it is Medical Exemiliar must 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: 1951-53 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) automobile salesman 0 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Arnestina unknown Nazerene Corsi ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 33 Richmond St., Hagerstown, Maryland 21740 Doris V. Corsi - wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 3/11/04 Hagerstown, Maryland permit. Pag Department Important: If any injury or Rose Hill Cemetery ⁴ 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service L 22 Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 10 Eglan Priysician unan /Medical Due to (or as a consequence **Examiner** Sequentially list conditions, if any, leading to immediate any. Leading to immediate any Enter Underlying. Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. the 9 Unknown been signed by t should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 4 Donknown 1 Yes 2 No 3 Probably Completed 24b. Were aulopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an Jas page 2 certificate 1 ☐ Yes 2 DNO or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 NOutpatient 1 Inpatient 3□ DOA 2 After this luneral 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A completely filled in by the fu 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medicai (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie DH-Wil 004 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person Anheta 00 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 09 Registrar

State of Maryland / Department of Health and Mental Hygiene 2004 08927 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Yeer Physician 6300 AM *yarch* Marjorie Freeman Campbell 2604 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Washington County Hospital Hagerstown If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Months 1 ☐ M 2 💢 F 91 Yrs. Director Oct. 28 1912 Pennsylvania 219-20-3079 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylai Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, If a Medical Exact it without be modified at 1 ☐ Yes 2 X No Director Maryland Washington Williamsport 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 16505 Virginia Ave. 21795 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No 1 □ Never Married 2 □ Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 21⁄2 No Specify: Specify:White If Yes, Give Year or Dates: þ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Personal Residence Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Florence Parshall 2 Charles Maxson Freeman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephen Campbell/Son 119 E.Thetford Rd. Lyme, N.H. 03768 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Rest Haven Cememtery | Mar. 8,04 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eatern Blvd. N. Hagerstown, Maryland 21742 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between set and Death Immediate Cause (Final disease or condition resulting in death) Physician erepa /Medical Due to (or as a consequence of): **Examiner** vascular Disegra 25 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Exan iner or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): P.O. Box 68760 the attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year detached for Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Division of Vital Records, 2**X** No 3 Probably 4 Unknown Be Completed been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 1 Yes funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Inpatient Other: 4 \(\) Nursing Home 5 \(\) Residence 6 \(\)Other (Specify) 1 Yes ZNO 2 ER/Outpatient 3 DOA Certification: To this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Magner of Death 28b. Time of 28d. Describe how injury occurred After 5 Pending Injury s after devel Director: Atte Natural 2 Accident 1 Tyes 2 No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and little of certifier D17591 ame and address if person who completed cause of death (Item 23a) (Type. Print) 9×10 Hazerstown Maryland Campus Rd Medica Newman 11110 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 0 Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 200

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	3. Time of Death	
r	10.40	

		Certificate of Death	Reg. No.	04 00526
	1. Decedent's Name (First, Middle, Last)		2. Dete of Deeth Month Dey	3. Time of Death
Physiciar /Medica Examine	Elizabeth Frances DEAVERS	4b. City, Town, or Lo	March 2 200	4 10:40 a.m.
Examine	Julia Manor Health Care Center	Hagersto	wn Washi	ngton
Funeral Director	5. Social Security Number 213-24-7973 5. Social Security Number 1	st birthdey) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.		9. Birthplace (State or Foreign Country) Maryland
9	Usuel Residence of Decedent			
sryler show		Town or Location		10d. Inside City Limits 1 ☐ Yes 27 No
M Pe M	Maryland Washington	Hagerstown	40- 02	
A Para	10e. Street end Number	10f. Zip Code	10g. Citizen of Wh	et Country?
sath v	14223 Pennsylvania Avenue 11 Marital Status 12 Was Decedent Ever in U.S.	21742	U.S.A.	American Indien,
BAITIMORE, MARYIANG 21215-0020 permit. Peges 1 and 2 should be filed within 72 hours effer death with the Meryland Depertment of Heelth and Mentel Hygiene. Important: if item 27 is married other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at any injury or other traumatic.	11. Marital Status 1	 13. Was Decedent of Hispanic Origin? (Spilf Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☒ No Specify: 	Rican, etc.) Black, Specify:	White, etc. White
2 ho	15. Decedent's Education	16a. Decedent's Usual Occupation (Give kind of work done during most of work)	16b. Kind of Busi	ness/Industry
1 21213-UU2U led within 72 hours ef ygjene. ver than "natural", or nt, the Medical Exam	(Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 1	lite. DO NOT use retired) Nurse	Hospit	al
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end 2 end 2 eeith n 27 I		14223 Pennsylvania Ave		
Saltimore, bernit. Peges 1 el Bepertment of Hee mportant: If Item; iny injury or othe	1 🕅 Burial 2 ☐ Cremation 3 ☐ Removal from State	ce of Disposition (Name of netery, crematory or other place) ar Lawn Mem. Park	Date 20c. Location - Ci	•
Balti permit. Depertminimportal any inju	21. Signature of Funeral Service Licensee	Name and Address of Facility Mir.	nich Funeral Ho	me
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deal of the ett	Part It. Other significant conditions contributing to death but not resulting	ng in the underlying cause given in Part I.	23b. Did tobacco use contr	ibute to the cause of death?
of the d by the leteched			1 □ Yes 2 1 No 3	Probabty 4 Unknown
The law requires that the death cer sate has been signed by the ettendir page 2 should be deteched for use			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
he la e ha: ege 2			1LLYas 212No	1 ☐ Yes 2 ☐ No
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To the Hospital or Attending Physician: The law within 24 hours effer death. To the Funeral Director: Atter this certificate has completely filled in by the funeral director, page 2			28d. Describe how injury occurred	
To the Hospital or Attending Pl within 24 hours effer death. To the Funeral Director: Attent completely filled in by the funeral	3 ☐ Suicide 4 ☐ Homicide 3 ☐ Suicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Homicide 5 ☐ Could not be determined 6 ☐ Could not be determined 9 ☐ Could not be determined 9 ☐ Could not be determined	e, farm, street, factory, office	28f. Location (Street and Number City or Town, Stete)	or Rural Route Number,
n 24 hour n 24 hour ne Funera pletely fille	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of exemination and manner stated.			
To th To th comp	29b. Signature end title of certifier	29c. License number	29d. Date signed (Month, Day, Yeer)
1	fand miles	00060396	3/2	104
54	30. Name and address of person who completed cause of death (Item 23)		logersteurn, ma 2	1740
State Registrar				

Registrar

FEB 2 6 2004

State of Maryland / Department of Health and Mental Hygiene 2004 For State Registrar Certificate of Death 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 6 34 Month **Physician** Thomas James Dale SR. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner SAL1364141 Kegional Medical Centh NICOMICO PENINSULA ff Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Oct.12 1945 Maryland 58 Director 215-44-6244 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Items 23a or 28a-f show 1 and 2 should be filed within 72 hours after death with the Marylar Health and Mental Hygiene. Health and Mental Hygiene. It is marked of other than "natural", or Items 23a or 28a-1 show then traumatic event, Its Medical Exprinest materials to notified at 1 XYes 2 □ No Director Salisbury Maryland Wicomico 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A 21801 425 Patrick Avenue Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 (★No 1 □ Never Married 2 □ Married 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates: Specify: Be Completed by 3 Widowed 4 Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 2/5 - 44 - 6 Maryland 21215 Elementary/Secondary (0-12) College (1-4or 5+) None 12 Laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be Department of Health and Mental Important: It item 27 Is marked of any injury or other traumatic evi ဂ Mary Dale Frank Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 425 Patrick Ave.Salisbury,Md.21801 Mary Dale Wilson (Mother) Baltimore, 20b. Ptace of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ★Burial 2 Cremation 3 Removat from State * 4 ☐ Donation 5 ☐ Other (Specify) Green Acres 2-28-04 Salisbury, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Homey, Md. 21801 Hladys Stewar Bi 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) NEUMONIA **Physician** /Medical Due to (or as a consequence of): Examiner VALVE SURGERY STENOSIS / TIL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physiclan/Medical Examiner The law requires that the death certificate be executed burial-transit FAILURE KENAL Due to (or as a consequence of): Box 68760, the for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) P.0. detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, page 2 should be 3 ☐ Probably 4 ☑Unknown 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 220No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 25. Was case referred to medical funeral director 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 3□ DOA Certification; To 1 Yes 2 ER/Outpatient 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. fnjury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. investigation hours after deat uneral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) à 4 - Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) ine Blu Salisbury, md. Nicholas y Year) 3 2 5 burn 31. Date filed (Month, Day, 32. Registrar's Signature State 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 2001 08931 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) March ^D**3**^y4 **Physician** 2ď64 4:47 DM Raymond Henry Decker /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Carroll Sykesville Continuum Care at Sykesville 8. Date of Birth
July 20 1921 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 120 M 2□ F MD 82 Director 161-14-5367 Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show traumatic event, the Medical Examinar dust be notified at 1 ☐ Yes 2X No Finksburg Funeral Director MD Carroll 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or Items 23a or 21048 USA 2928 Cedarhurst Road 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. ont: If Item 27 is marked other than "natural", or Item 1939 1X Yes 2 □ No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Il Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify: White Completed by 1945 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Baltimore Gas and Elementary/Secondary (0-12) College (1-4or 5+) Electric Cable Splicer 12 17 Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be unknown unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2928 Cedarhurst Road Finksburg, MD 21048 permit. Pages 1 and 2 Department of Health a Importent: If Item 27 Is any injury or other trai <u>once</u>. Mary Decker/wife 20c. Location - City or Town, Stete 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 3/8/2004 1 Burial 2 Cremation 3 Removal from State *4 □ Donation 5 □ Other (Specify) Evergreen Memorial Gardens Finksburg, MD 21. Signature of Funeral Service Pritts Funeral Home and Chapel, P.A. <u>211</u>57 412 Washington Road Westminster, MD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** ementa disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner or Attending Physicien: The law requires that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical the detached for use as 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) o 9 Unknown 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by Division of Vital Records, pe 3 ☐ Probably 4 ☐ Unknown 1 □ Yes 2 □ No. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 1 🗆 Yes 2 □ No 2 N 1 TYes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ursing Home 5 Residence 6 Other (Specify) 1 Yes 2 THO Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Setural 5 Pending s after death. 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) l in by 4 - Homicide To the Hospital within 24 hours To the Funerel 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only onel and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and -0054218 Malcalmaline Westminter MD 21157) 30. Name and address of person who complete Fernera amar 32. Registar's Signature 31. Date filed (Month, Day, Year) State MAR 0 8 2004 Registrar

State of Maryland / Department of Health and Mental Hygiene 2001.

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al age	Physic /Medi		Clarence Floyd	Davis, S	Sr.				March	^{Dey} 2	004°	2:35 am
7	Examir		4a Facility Neme (If not institution, gir	ve street end number))			4b. City, Town, or	Location of Death			
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	Funeral Director		220-26-5756	Sex 7. Ag 1 XX M 2□ F	ge (In yrs. les 80	t birthdey) Yrs.	If Under 1 Year Months Days			, 1923	9. Birthpla Country Mar	ce (State or Foreign y) y land
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E	75 2		Betty L. Davis -					on Lane				
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of Vital Records,	requi	ete	diabetes me	llitus					24a. Was a perfori		availa	autopsy findings able prior to eletion of cause
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Ö	s efte	Certification:	4 ☐ Homicide	building, efc	. (Specify)				City or Town	n, State)		
	To the Hospital or Attending Physician: The lew within 24 hours efter deeth. To the Fureral Director: After this certificate hes completely filled in by the funeral director, page 2	edical (29a. Certifier 1 Certifying Ph	ysician: To the best of	of my knowled	lge, deeth o	occurred at the tin	ne, date and place	o, and due to the ca	ause(s) and ma	nner es state	ed.
	the the the f		une)	and manner ste	ted.							
			29b. Signature and title of certifier April Rea Ke	TT.	0		29c. Licens			9d. Date signed		
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n	4.471		30. Neme and eddress of person who counthia Kuttner-S					Willi	amsport,	MD 21	795	
	Sta	e		32. Registre	r's Signature		/	., 111111	amopore,	-111 21	. , ,	
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State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Yee **Physician** 9:30 a M 2004 March 04 Joan Marbury Barton Eason /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner Carroll 1532 S. Pleasant Valley Road Westminster | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | May | 17 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 5. Social Security Number **Funeral** 1 ☐ M 2X F 1930 MD 73 Director 215-28-8171 Usual Residence of Decedent permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturel", or Items 23a or 28e-f ehromany injury or other traumatic event, the Medical Experiment. 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 1 Yes 2 No Director Westminster MD Carroll 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1532 S. Pleasant Valley Road 21158 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married White 1 ☐ Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Ada M. Beall John M. Barton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1532 S. Pleasant Valley Road Westminster, MD 21158 Richard K. Eason/husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 3/06/2004 1 ⊠Buriel 2 □ Cremation 3 □ Removal from State Pleasant Valley Cemetery Pleasant Valley, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Pritts Funeral Home and Chapel, P.A. 21157 412 Washington Road Westminster, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic PUNCREATIC MONTHS Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): the burial-Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy has 1 Yes or Attending Physician: Director: After this certific I in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospitaf: 1 Inpatient Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 2 No 2 ER/Outpatient 3 DOA Certification: To 1 Tes 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Injury 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 6 Could not be 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined after 4 Homicide within 24 hours a To the Funerel L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2 DS8757 2004 HLUMKAL MD MJL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20 CRB # 186 1650 ORLGANS ALUMKAL 32. Registrar's Signature State Gerena D. Societi Registrar MAR 0 5 2004

		1 = For State Registrar	State of Maryl	and / Depa	artment of rtificate of	Health and Death		giene 20	04 08931
Physic /Med	ical	1. Decedent's Name (First, Middle, Last)					2. Date of De Month	Day 29	Year 3. Time of Death
Exam	Ţ	4a. Facility Name (If not institution, give shall be a NCHORAGE NURSING 5. Social Security Number 6. Sex	& REHAB CEN		SALI	SBURY		4c. County o	IICO
Funera Directo			7. Age (In) М 2xx F 76	rs. last birthday) Yrs.	If Under 1 Yea Months Days		10/06/	^h , Year) 1927	9. Birthplace (State or Foreign Country) New York
6 after death with the Maryland or flems 23a or 28a-f show itner must be notified at	ctor	10a. State 10b. County Maryland Wicomico		City, Town or Lo					10d. Inside City Limits 1 1 Yes 2 □ No
th with the 23a or 28	ai Director	10e. Street and Number 105 Times Square			10f. Zip Code	801		10g. Citizen of Wh	nat Country?
and 21215-0036 be lifed within 72 hours after death with the Maryland stal Hygiene. d other than "natural", or items 23a or 28a-1 ehow event, the Madical Exertified at	by Funeral	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify Cult		(Specify Yes or No- erto Rican, etc.)	14. Race Black,	- American Indian, White, etc. White
21215-0036 d within 72 hours aff giene. or than "natural; or I ha M dical Extra	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual Occu kind of work done DO NOT use retire	during most of ved)	working	16b. Kind of Busi	,
Maryland 2 Id 2 should be filed the and Mental Hygie ty 1s marked other traumatic event, III	To Be Co	17. Father's Name (First, Middle, Last) William M Fisk	4 .T	SCHOOL	ol Teach	T	lame (First, Middle,	Maiden Sumame)	ary Education
		19a. Informant's Name/Relationship (Type George W. Fisk/bro	other	924	4 Winding	t and Number or	Rural Route Number Salisbury,	r, City or Town, St	
Baltimore, permit. Pages 1 ar Department of Hea mportant: If Item: In Injury or other page.		20a. Method of Disposition 1 🔀 Burial 2 Cremation 3 Rei 4 Donation 5 Other (Specify)	emoval from State	lenwood	cemeters	y 5/	1/04	20c. Location - Ci Oneonta	, NY
Balt permit. Depart Import		23a. Part I. Enter the disease, or complex	mpson C		OT SHOW	UTTT KO	· / Salisb	urv, MD 2	l Association 21804
Physician /Medical		shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each line.	MENTA	er the mode of dyl	ng, such as card	ac or respiratory arr	0 <i>s</i> t,	Approximate Interval Between Onset and Death
8760, ate be executed by thysician and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Cleases or injury that initiated events resulting in death) Last	Due to (or as a cons	equence of):					3
BOX 6 ath certific	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 me/hiths? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	ac. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	etal death 3 🗌	Ectopic pregnanc Other (specify)	y 		23d. Date o	,
cords, P.O. wrequires that the deben signed by the should be detached to	by	Part II. Other significant conditions cont	tributing to death but not r	asulting in the un	derlying cause giv	ren in Part I.			ite to the cause of death?
The ate h	Completed						24a. Was ar autops perform 1 Yes 2	y prio	re autopsy findings available r to completion of cause of th? Yes 2 \sum No
- × × 5	tion: To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation	ospital: 1 ☐ Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Injur Wor	er: 4 Nursing	Home 5 Reside	nce 6 Other (Specify)
# # # E	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm, stre			28f. Location (Str City or Town	reet and Number o , State)	or Rural Route Number,
To the Hospital of within 24 hours at To the Funeral Completely filled it	fedical	one)	cian: To the best of my kr er: On the basis of examir and manner stated.	nowledge, death nation and/or inve	estigation, in my o	pinion, death occ	ee, and due to the ca curred at the time, da	use(s) and manne ite and place, and	or as stated. due to the cause(s)
To To	×	29b. Signature and title of certifier			29c. Licens	e number		3/1/04	
PC		30. Name and address of person who com	1415	5. DIV			GALIST	3/1/05	> 21804
Sta Registr		31. Date filed (Month, Day, Year) MAR 0 1 200	32. Re jistrar's Sign	nature 4	Spark	2			

State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** Dewey L. Fortner March 4, 2004 12:02 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4e. Fecility Name (If not institution, give street and number) Examiner Fort Washington
der 1 Year | If Under 24 Hrs. | 8.
ns | Days | Hours | Min. Prince George's Fort Washington Hospital If Unde 8. Date of Birth (Month, Dey, Year) Birthplace (Stete or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number 1□M 2□F **Funeral** Months North Carolina Nov 2, 1928 Director 242 36 6195 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No maryland Prince Clinton, Direct 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 238 8705 Old Branch Ave 20735 United States death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S.
Armed Forces?

12. Was Decedent Ever in U.S.
Armed Forces?

WWII
Yeas, Give
Year or Dates: 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If tiem 27 ie markad other than "natural", or ite any injury or other traumatic avent, tha Medical Examina. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2√X No Specify: ۵ 3 Vidowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Police Law Enforcement 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Forest E. Fortner Flora C. Price 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8705 Old Branch Ave, Clinton, Maryland 20735

e of Disposition (Name of March Pate 2004, 20c. Location - City or Town, State Teresa Fletcher (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) March 8, 2004 20a. Method of Disposition 1 Durial 2 Cremation 3 Removal from State Resurrection Cemetery Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d 21. Sign tive of Funeral Service Licensee Alexandria Ferry Road, Clinton Maryland 20735 Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) tneumonia **Physician** 5da /Medical Due to (or as a consequence of): **Examiner** oBstructive line Disease Chronic Sequentially list conditions, 131y cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner Hospitel or Attending Physician: The law requires that the death certificate be executed as the burial-transit and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 attending physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy 1 Live birth 2 Fetal death Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No be detached 9 Unknown 9 Unknown á signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed 1 ☐ Yes 20 No ours after death.

nerel Director: After this certific filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1. Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 21 XNo Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day Yeer) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 XX Vatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide 24 hours a 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical within 24 ho
To the Fune
completely fi 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 145365 03-042004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1170/ livingston ad HIOI, frugiling Sidgrani Michael 31. Date filed (Month, Day Year) MAR 1 0 2004 32. Registrar's Signature State Educa Registrar

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** Fletcher James Nathaniel 3:35 March 4, 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2985 Ponds Wood Road Calvert Huntingtown If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 ▼ M 2 □ F 216-22-1323 Director 76 4,1928 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits 28e-f show . If them 27 is marked other than "natural", or items 23a or 28e-f sho or other traumatic event, the Macical Examinal must be notified at 1 Yes 2 No Maryland Calvert Huntingtown Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2985 Ponds Wood Road 20639 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Xes 2 No 1946 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1□ Yes 2M No Specify: Completed by If Yes, Give Year or Dates: 1947 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Naval Research Laborer 12 permit. Pages 1 and 2 should be filed Department of Health and Mental Hygis Important: If Item 27 is marked other any injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Fletcher Nathaniel Maggie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2985 Ponds Wood Rd. Pauline Fletcher/wife Huntingtown, MD 20639 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Plum Pt. UMC Cem. 3/12/2004 Huntingtown, MD ` 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Sewell 1451 Dares Beach Rd. Funeral Home Prince Fred., MD20678 21. Signature of Funeral Service Licensee Blacky a. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, any leading to infine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit the attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical as the IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Day ō Month Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) signed by the al ☐Yes 2☐No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Tunknown 1 Yes 2 No peen (24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? this certificate 2 11 N or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral 28a. Date of Injury (Month, Day Year) after death. I Director: After the 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6+1 Prince Frederick, MD 20678 Mukesh Mathur D 31. Date filed (Month, Day, Year) 32. Registra's Signature State 2004▶ MAR 0 5 Registrar

			1 - For State Registrar	State of Mary	land / Depa <i>Cei</i>	artment of H	lealth and l Death		ene 2001	08937
	Physici /Medic		1. Decedent's Name (First, Middle, Last)	OX				2. Date of Death Month M CMU	Day / Year	3. Time of Death 4 03:15 9 M
	Examir			y General			Colum	ubia	4c. County of Dee	oard
	Funeral Director		5. Social Security Number 6. Septimber 412–28–6442 Usual Residence of Decedent	IN JOSE	yrs. last birthday) 86 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, NOV. 9, 10	year) 9. Bir 917 Hawk	thplace (State or Foreign puntry) INS, TN
	e Maryland Ba-f ahow	ctor	MD Howard	100	c. City, Town or Lo Elkridge	cation				10d. Inside City Limits 1 🛱 Yes 2 ☐ No
	s 23a or 2 ount be o	Funeral Director	10e. Street and Number 6802 Donsey Road			10f. Zip Code 21075			g. Citizen of What Co USA	
036	ours after de ai', or item Exeminati	þ	11. Marital Status 1 Never Married 2 Married 3XX Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes XX No If Yes, Give Year or Dates:	11	Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit Specify:	
1215-0	within 72 hours after death with the Maryland ene. then "naturel", or liems 23s or 28s-f show he Medical Ezamaine maid be nyillied at	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	(Give	ent's Usual Occupa kind of work done of OO NOT use retired	turing most of wor	king	6b. Kind of Business	•
Baltimore, Maryland 21215-0036	be filed ital Hygi od other avent, I	To Be Co	17. Father's Name (First, Middle, Last) Unknown		nou	sekeeper	18. Mother's Nam	ne (First, Middle, M. Lane	State Hosp aiden Sumame)	Ital
, Mary	and 2 should ealth and Mer n 27 is marke ier traumatic		19a. Informant's Name/Relationship (Type George Lane - Son	pe, Print)			and Number or Ru		City or Town, State, 2	Zip Code)
timore	Pages 1 and theal of Heali tant: If Item 2 ljury or other		20a. Method of Disposition XX Burial 2 □ Cremation 3 X R '4 □ Donation 5 □ Other (Specify)	emoval from State	Rest Haven	Cemetery	March		Hanover, PA	
Bai	permit. Departrimports Imports any inju		21. Signature of Funeral Service License 23a. Part 1. Enter the disease, or compli		C0354 Ken		eral Home,			, Hanover, PA
	Physician /Medical Examiner		shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	Due to (or as a cor		neum e ani			1,	Approximate Interval Between Onset and Death
8760,	icate be executed physician and s the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cor	Deal	eles ensio	21			
P.O. Box 68	death certif e attending od for use a:	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \(\text{Ves} \) 22 \(\text{No} \) 9 \(\text{Unknown} \)	3c. If yes, outcome of pro 1 Live birth 2 4 4 Pregnant at time 9 Unknown	Fetal death 3 🗌	Ectopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year
	sign d be	by	Part II. Other significant conditions con	tributing to death but not	t resulting in the un	derlying cause give	n in Part I.		cco use contribute to	
Vital Records,		Completed						24a. Was an autopsy performe	prior to d	topsy findings available completion of cause of
Zi Et	Phyeician: Th this certificate rai director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	ospital:	a [7 sp.o.	3C DOA Othe	_	th (Check only one)		
Division of	uttending Phyedeath. ctor: After this y the funeral di	ation: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea	2 ER/Outpatient 28b. Time of Injury	28c. Injury Work	at	28d. Describe how	ce 6 Other (Specinjury occurred	ify)
Divis	or A Ifter Direction by	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - / building, etc. (Sp	pecify)			City or Town,		
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medical	29a. Certifier (Check only one) 2 Medicel Exeminate of certifier	ician: To the best of my lar: On the basis of exan and manner stated.	mination and/or invi	estigation, in my op	inion, death occur	red at the time, date	and place, and due	to the cause(s)
1			· Sac	d_ r	(Nem 20-) 7	2ac. License	5087	0 Y	nauch 3	Day, Year) 31029
C	ري Sta	te	30. Name and address of person who con Suran Abd 31. Date filed (Month, Day, Year)	32. Registrar's S	ignature (Type, F	1 bell	ln. C	larksi	ell m	21029
, in	Registr		MARUO	ZUU4 > AZKORO	we the	Goods				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 () () Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 4:10 AMM **Physician** March 2. 2004 Roger Leatherman Fiery, Sr. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Washington County Julia Manor Health Care Center Hagerstown Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Days Hours **Funeral** 1**√**M 2□F May 17, 1905 Maryland 98 212-38-9809 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 72 hours after death with the Maryland 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examinat must be mailfied at 1 ☐ Yes 2 ☐ No Hagerstown Director Washington Co. Maryland 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number U.S.A. 21742 10943 Mapleville Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: Maryland 21215-0036 White 3 ₩ Widowed 4 Divorced Completed by 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) within College (1-4or 5+) Elementary/Secondary (0-12) Private Practice Chiropractor 18. Mother's Name (First, Middle, Maiden Sumame) marked other 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important: If item 27 is marked othv any injury or other traumatic evant. Be J. Florence Leatherman Frisby Tilghman Fiery 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10939 Mapleville Road Hagerstown, Md. Roger L. Fiery, Jr. / Son 20c. Location - City or Town, State Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hagerstown, Maryland Rest Haven Cemetery Mar. 8,2004 * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Douglas A. Fiery Funeral Home 1331 Fastern Blvd. N. Hagerstown, Md 21742 Douglas A. Fiery Funeral Home 1331 Eastern Blvd. N. Hagers shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Pneumonia /Medical Due to (or as a consequence of): Examiner Renal Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physicien; The law requires that the death certificate be executed physicien and s the burial-transit Due to (or as a consequence of): Box 68760, by Physician/Medical as 23d. Date of delivery If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month in the past 12 months? 4□Pregnant at time of death 5 Other (specify) ed by the a detached f 1 ☐ Yes 2 ☐ No P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2**X** No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑ No 2 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of 27 Manner of Death Certification: After 5 Pending 1 XNatural 1 ☐ Yes 2 ☐ No 2 Accident investigation death. after death the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide in by 4 - Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier March 2, 2004 D0060396 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hagerstown, Md 21742 1126 Opal Court Dr. Farid Murshed

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Y

ORIGINAL

32. Registrar's Signature

Receive.

For State Registrar 1. Decedent's Name (First, Middle, Last)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Stat

e of Maryland / Department of Health and N Certificate of Death	Mental Hygiene	2001	กลด	3.50
Certificate of Death	Reg. No.	2004	005	00:
	2. Date of Death		3. Time of D	eath

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Physician	l
/Medical	ŀ
Examiner	ŀ
	l

Archie Harold Goldsmith, Sr.

Day 4, 2004 Month March

5:15P ^M

1 ☐ Yes 2X No

4a. Fecility Name (If not institution, give street and number) 9817 Sylvan Turn

4b. City, Town, or Location of Death Newburg

4c. County of Deeth Charles

Funeral

217-32-4039 Usual Residence of Decedent

7. Age (In yrs. last birthday) 157M 2□ F 68

 Birthplace (State or Foreign Country) Maryland

Director

or 28a-f show

Director

Completed by Funeral

Be

Examiner

Completed by Physician/Medical

Be

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Certification:

Medical

f Health and Mental Hygiene. Itam 27 is marked other than "natural", or Itams 23s or 28s-f show other treumatic event, the Medical Examinar must be notified at

permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: if Itam 27 is marked oth any injury or other treumatic event, once.

Physician /Medical

Examiner

and

attending physician

the

The law requires that the death certificate be executed

or Attending Physician:

the Hospital

death.

within 24 hours after deat To the Funerel Director:

Division of Vital Records, P.O. Box 68760,

transit

burial-

as the

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for

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page 2

in by the funeral

pelli

Hrchie Goldsmith Maryland 21215-0036

Baltimore,

10b, County 10a. State Charles 10c. City, Town or Location

Newburg

10d. Inside City Limits

MD 10e. Street and Number

5. Social Security Number

9817 Sylvan Turn

10f. Zip Code 20664 10g. Citizen of What Country?

USA

1 Never Married 2 Married 3 ☐ Widowed 4 ☐ Vivorced

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐¥es 2 ☐ No If Yes, Give Year or Dates:

 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2XNo Specify:

14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

Elementary/Secondary (0-12)

College (1-4or 5+)

Mechanic

Heavy Equipment

17. Father's Name (First, Middle, Last)

Archie Theodore Goldsmith

18. Mother's Name (First, Middle, Maiden Sumame) Catherine Elizabeth Rice

19a. Informant's Name/Relationship (Type, Print) Margaret Jenkins/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13536 Southview Rd. Newburg, MD. 20664

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State ⁴ 4 □ Donation 5 □ Other (Specify)

(chu

20b. Place of Disposition (Name of cemetery, crematory or other place) United Methodist Cem. 3/9/04 La Plata, Maryland

20c. Location - City or Town, State

21. Signatura of Funeral Service Licensee

AREHART ECHOLS FUNERAL HOME, P.A. BOX 567 LA PLATA, MD 20646

auns

Immediate Cause (Final disease or condition resulting in death)

dequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complications that caused the deast only one cause on each line.	ath. Do not enter the mode of d	lying, such as cardiac or re-	spiratory arrest,
Immediate Cause (Final disease or condition	Suddle	n Cordia	e Deat	
resulting in death)				

Due to (or as e consequence of):

Due to (or as a consequence of)

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month

23e. Did topacco use contribute to the cause of death?

Day Year

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

2 No 3 Probably 4 | Unknown

24a. Was an autopsy performed? 1 ☐ Yes

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

00

20 602

25. Was case referred to medical examiner? 1 ☐ Yes ÀZ No

27. Many er of Death 1 Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide

Hospital: 1 | Inpatient 2 | ER/Outpatient 28a. Date of Injury (Month, Day Year)

3□ DOA 28b. Time of 28c. Injury at Work? Injury М

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Other: 4 Nursing Home Residence 6 Other (Specify) 28d. Describe how injury occurred

26. Place of Death (Check only one)

1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

4 Thomicide

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b Signature and title of certifier

29c. License number

29d. Date signed (Month), Day, Year)

ddress of person who completed cause of death (Item 23a) (Type, Print) 30. Name and

31. Date filed (Mon 2004

ON 32. R distrar's Signature

Registrar

DHMH 17 Rev 1/2001

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. David W. Grimes State of Maryland / Department of Health and Mental Hygiene 04 - 1557Certificate of Death AKG 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** David Grimes Wayne March 2004 2:59 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Taneytown
Under 1 Year If Under 24 Hrs. 8. Date of Birth
onths Days Hours Min. July 27, 1943 3957 Baptist Road Carroll

9. Birthptace (State
Country)

Maryland (State or Foreign 7. Age (In yrs. last birthday) Social Security Number **Funeral** Months 1 XM 2□ F 60 219-42-5191 Yrs Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10h County or 28e-f ehow ir then "naturel", or items 23a or 28e-f ehov the Medical Examiner must be multiped at 1 Yes 2 No Maryland Carroll Taneytown Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21787 3957 Baptist Road U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 X Married 1 ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) custodian public school 18. Mother's Name (First, Middle, Maiden Sumame) other treumatic event, 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be inent of Health and Mental Innt: If Item 27 Is marked o David E. Grimes Lillie Kathleen Weddle ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Dawn Waskiewicz/ daughter 3957 Baptist Rd. Taneytown, MD 21787 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 0 permit. Page Department of Importent: If eny injury or page. 3/5/2004 Beaver Dam Cemetery nr. Union Bridge, MD 4 □ Donation 5 □ Other (Specify) 21. Simat re of Fineral Service L 22. Name and Address of Facility HartzlerFuneral Home athanine E. Broadway Union Bridge, MD 21791 Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each lige. tmmediate Cause (Finat **Physician** resulting in death) /Medical **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) attending physician a for use as the burial: P.O. Box 68760, Physician/Medical as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year in the past 12 months? 4☐ Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part It. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, à 2/10/No 3 Probably 4 Unknown 1 ☐ Yes Completed certificate has been s rector, page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed page Yes 2□ No 2 No 26. Place of Death C eck on one 25. Was case referred to medical Be Other: Hospital: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) At Scene 1 X 1 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death After 1 Naturat 5 Pending 04 1 Yes ec death. investigation 2 Accident within 24 hours after death To the Funerel Director: the 6 Could not be Suicide Ptuse of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Struct and Number or Rural Route Number, 289 filled in by one 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(1) and manner as stated.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Ch only 29d. Date signed (Month, Day, Year) 29b. Sign Wire and tille of q 29c. License number NI March 2, 2004 O.C.M.E. ompleted cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 0 2004 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

			1 _ State		artment of Health			2001	. 0001.1
			Registrar 1. Decedent's Name (First, Middle, Last)	00.	illicate of Deat		Reg. No	ه. کـ ۲۰۰۰	3. Time of Death
	Physici /Medi		Denise		Hall	Te	Month Da	28, 2004	1 18: 17 W
	Examir	ier	4a. Fecility Name (If not institution, give street and number) The Johns Holkins Hospita	ri l	4b. City, Town, or Location	on of Death	40	c. County of Deeth	h
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In	yrs. last birthday) 52 Yrs.	If Under 1 Year If Und Months Days Hour	der 24 Hrs. 8. rs Min. Ar	Date of Birth (Month, Day, Year Dr 13, 19	9. Birth Con Mar	hplece (Stete or Foreign unity) Cyland
	and		Usual Residence of Decedent 10a. State 10b. County 10c	. City, Town or Lo	ocation				10d. Inside City Limits
	Mary a-f sho	tor	Maryland Harford		Aberdeen				1 ☐ Yes 2 💆 No
	or 284	Director	10e. Street and Number		10f. Zip Code		10g. Ci	itizen of What Cou	untry?
	s 23a	Frail	601 Burton Manor Apt. 213	: 40	21001			USA	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any njury or other traumatic event, It a Medical Examination must be incitied at once.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Dovorced 12. Was Decedent Ever Armed Forces? 1 Yes, Sive Year or Dates:	j	Was Decedent of Hispanic of Hispanic of the state of the		Yes or No- in, etc.)	14. Race - Amer Black, White Specify: Bla	e, etc.
2-0	72 ho	eted	15. Decedent's Education (Specify only highest grade completed)	16a. Dece	dent's Usual Occupation kind of work done during m DO NOT use retired)	nost of working	16b. K	Kind of Business/li	ndustry
12	within ene. then	Completed	Elementary/Secondary (0-12) College (1-4or 5+)		rses Aide		11	S Govern	mont
	il Hygi other	8	17. Father's Name (First, Middle, Last)	, Na		other's Name (Fil	rst, Middle, Maider		meric
ylar	Suld by Menta arked atic sy	To B	George Minor			livia Jo			
Maryland	d 2 sh th and 7 is m fraum		19a. Informant's Name/Relationship (Type, Print)		ng Address (Street end Num				ip Code)
	f Heali f Heali item 2 other			b. Place of Dispo	Cornell Stree sition (Name of natory or other place)	Date		ocation - City or T	Town, State
Ē	Page nent o ent: If ury or		1 ☐ Burial 2 Macremation 3 ☐ Removal from State 1 ☐ Donation 5 ☐ Other (Specify)		is & Co., Ind	c. 3/5/0	4 Wes	t Cheste	er, PA
Baltimore,	permit. Departiments Importe any inji		21. Signature of Funeral Service Licensee	22	Name and Address of Fac Lisa Scott 552 Lewis S	Funeral Street.	Home, P Havre de	.A. Grace.	MD 21078
			23a. Pert1. Enter the disease, or complications that caused the c shock, or heart failure. List only one cause on each line.	death. Do not ent	er the mode of dying, such	as cardiac or res	piratory arrest,		Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	en f	ternsat.	SON			Onset and Death 3 days
	Examiner		Due to (or as a con	sequence of):	Levas at.	6-	2		21 /2
0	D ==	ner	if any, leading to immediate cause Frier Underlying		, the second	nag	<i>[6</i>		ar anys
7	and I-trans	Examiner	Cause (Diseese or injury that initiated events resulting in death) Last Due to for as a con		5/01				10 years
8760,	cate be executed physician and the burial-transit	dicai E	d	304001100 017.					<i>'</i> .
9		a •	IF FEMALE:						-,
Вох	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	etal déath 3 🗆	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ery Day Year
o.	that the de led by the a detached f	hysic	1 U Yes 2 No 9 Sunknown 9 Unknown	01 094(11 5	Other (specify)				,
o,	es that igned b	by P	Part II. Other significant conditions contributing to death but not	resulting in the ur	nderlying cause given in Par	rt I.	23e. Did tobacco u	use contribute to t	the cause of death?
ord	w requir been s should						1 Yes 2	□No 3□Prob	bably 4 Unknown
Records,	The law sate has b page 2 s	Completed					24a. Was an autopsy performed?	24b. Were auto prior to co death?	opsy findings available ompletion of cause of
Vital		0	25. Was case referred to medical		26 Pla	ice of Death (Ch	I□Yes 2XNo		2 □ No
<u>></u>	S S D	To B	examiner? 1 ☐ Yes 2 XNo Hospital: 1 XInpatient 2	2 ER/Outpatien	Other		5 Residence	6 □Other (Specil	(y)
Division of	ding After fune	ion:	27. Manner of Death 1 Natural 5 ☐ Pending 28a. Date of Injury (Month, Day Yee)	28b. Time of Injury	Work?		Describe how injur	y occurred	
/ISIC	deatl ctor: y the	ficat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - A	at home, farm, stre	M 1 ☐ Yes 2 [eet, factory, office		ocation (Street an	nd Number or Run	al Route Number
á	s after	Certification:	4 Homicide determined building, etc. (Sp.	ecify)	,,		City or Town, State)	ar route reamber,
	To the Hospitel or At within 24 hours after or To the Funeral Dirac completely filled in by	edical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my 2 Medicel Examiner: On the basis of exam and manner stated.	knowledge, death nination and/or inv	occurred at the time, date a restigation, in my opinion, de	and place, and death occurred at	lue to the cause(s) the time, date and	and manner as si i place, and due to	stated. o the cause(s)
•	To the Comp	Me	29b. Signature and title of certifier		29c. License number			te signed (Month,	
7	2		1 de de Mo		RES-C	000	Feb	lruary	28,2004
	5	į	30. Nam /a d address of per n who completed cause of death (I	(Type, F	RES-C	B. 17	MARKS	41 2	297
4	Sta Registra	-	31. Date filed (Month, Day, Year) 32. Registrar's Si	gnature .	well of	- 1 /	, , , , , , , , , , , , , , , , , , ,		
		- 45	MAR 0 2 2004	State of the state	1420				

			For State	State of Marylan				and Meni	tal Hygien		1 00010
			Registrar 1. Decedent's Name (First, Middle, Las	"	Cei	rtificate of	Death	2. D	Reg. No		3. Time of Death
	Physici /Medic		William	HITCHENS					Month Da	6 Zac	4 09:35AM
35	Examin		4a. Fecility Name (If not institution, give	1 111-	161	4b. City, Town, o	(Deeth	0 4	County of De	
	Funeral		5. Social Security Number 6. Se	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 2		ate of Birth fonth, Day, Year	Baltimo	rthplece (Stete or Foreign country)
	Director		222-18-9746	X M 2 □ F 71	Yrs.	Months Days	Hours		1y 4, 19		laware
	yland 10w		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	cation					10d. Inside City Limits
	Ba-fsh	Director	DE Sussex	Lau	re1						1 ☐ Yes 2½ No
	with the a or 2		10e. Street and Number	11 1		10f. Zip Code	E 6			itizen of Whal C	ountry?
	death ms 23	Funeral	16847 Hard Scra	12. Was Decedent Ever in U.	S. 13.1	Was Decedent of I	Hispanic Orio	gin? (Specify)	res or No-	14. Race - Am	
36	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, tra Mcdisal Exerting must be notified at	by Fu	1 ☐ Never Married 25 Married	Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give 1952— Year or Dates:		f Yes, specify Cub 1 ☐ Yes 2 ☑ No		i, Puerto Hicar	i, etc.)	Black, Wh	
5-0036	2 hours		3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Ed	ucation 19.	16a. Dece	dent's Usual Occup	pation		16b. I	Cind of Busines	White s/Industry
21215	ithin 7.	Completed	(Specify only highest grade Elementary/Secondary (0-12)	de completed) College (1-4or 5+)	life. i	kind of work done DO NOT use retire	d)				
2	filed w Hygien Sther th		17. Father's Name (First, Middle, Last)	12	Sch	ool Admi			t, Middle, Meide	iddle S	chool
Maryland	d fa b	To Be	William J. Hitch	ens				•	Brumbley	05	
lary	and and le m		19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailir	ng Address (Street	and Numbe	er or Rural Rou	te Number, City	or Town, State,	Zip Code)
	1 and Health em 27 ther t		Rebecca Hitchens 20a. Method of Disposition	(Wife)		7 Hard S	crabb:	le Road		e1, DE ocation - City o	19956
altimore,			1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Removal from State	emetery, crer	ws Cemet	1			rel, De	
att	permil. Pages Department of Important: If II any injury or o		21. Signature of Funeral Service Licen:		22	. Name and Addre nort Fune	ess of Facility	v	U4 Date	, D.	Haware
<u> </u>	2011		23a. Part 1. Enter the disease, or comp	t-Vewell		00 West S	Street	Laure	1, DE 1	9956	Approximate
	Physician		shock, or heart failure. List only of Immediate Cause (Final	one cause on each line.	ii. Do not ent	er the mode or dyli	ng, such as	cardiac or resp	matory arrest,		Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Seps(s Due to (or as a conseq	uence of):						
	Examiner	<u>.</u>	Sequentially list conditions, if any, leading to immediate	b. Metaal VIII	LVE K	placen	ut 5	ungla	<i>y</i>		20 DAYS
	uted d ansit	Examiner	cause. Enter Underlying Cause (Diseese or injury that initiated events		201100 017.						
760,	ate be executed hysician and he burial-transit		resulting in death) Last	Due to (or as a consequence	uence of):						
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ŏ	death certifica e attending pl d for use as t	M/W	23b. was decedent pregnant	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		Ectopic pregnanc	v			23d. Date of de	
O. B		Physician/Med	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐ Pregnant at time of do 9☐ Unknown		Other (specify)	,			Month	Day Year
a.	The law requires that the ste has been signed by the page 2 should be detache		Part II. Other significant conditions co	entributing to death but not res	ulting in the u	nderlying cause giv	ven in Part I.	2	23e. Did tobacco	use contribute	to the cause of death?
Records,	w requires been sign should be	ed by	Congestive Heri	+ trune					1 ☐ Yes 2	:□No 3,20 P	robably 4 Dunknown
eco	e law re has be je 2 sho	Completed	Abdominal Hon	hic Avenny	The			2	4a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of
			25. Was case referred to medical						performed? ☐ Yes 2 No	death?	
\leq	ysicla is cert directe	To Be	examiner?	Hospital: 1 Inpatient 2	ER/Outpatien	t 3 DOA Ot	200	of Death (Che	5 Residence	6 ☐Other (Sp.	ecify)
Division of Vital	Attending Physiclen: The Ir death. sctor: After this certificate has by the funeral director, page		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wo	ry at rk?	28d. D	Describe how inju		
/ISIO	Attendi death. ctor: A y the fu	flcat	2 Accident investigation 3 Suicide 6 Could not be	286. Place of injury - At no	ome, farm, str		Yes 2□N		ocation (Street a	nd Number or F	ural Route Number,
2	s after s after al Dire	Certification:	4 Homicide	building, etc. (Specify	1)	,			ity or Town, Stet		
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier (Check only one) 1 Certifying Phyone 2 Medical Exam	vsician: To the best of my kno iner: On the basis of examina	wledge, death tion and/or inv	occurred at the til restigation, in my	me, date and opinion, deat	d place, and di th occurred at	ue to the cause(s the time, date an) and manner a d place, and du	s stated. e to the cause(s)
	within 2. To the I complet	Mec	29b. Signature and title of certifier	and manner stated.		29c. Licens	se number		29d. Da	ite signed (Mon	th, Day, Year)
	ny M		-1-16/1.M	16h (00		PI-	772	6	Fes	man Z	6 2004
	IVA		30. Name and oddre s of person o o	omple ca e of death (Item	23a) (Type,	Print)	111	1.10	1 P	14	Cify MI)
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture	Gary/mod	/ Usa	ucal Q	APCK: DA	Murl	City 10(1)
	Registr	-	MAR 0 1	2004 Deneu	~ /	s apa	us				,

DHMH 17 Rev 1/2001

Registrar

			1 - For Stata Registrar	State of	f Marylaı		artment rtificate					g. No. 20	04	08945
	Physici	an	Decedent's Name (First, Middle Clara	Louise	۵	Hilli	ard				2. Date of Death Month March	Day 200	Year 1	3. Time of Death 4:05 a M
	/Medic Examin		4a. Facility Name (If not institution,			******	4b. City, T	Town, or	Location of	of Death		4c. County		, 1103 u
	LAGITHI	CI	Calvert Memoria	l Hospita	1		Pri	nce	Frede	eric	ς	Ca.	lvert	
	Funeral		5. Social Security Number		7. Age (In yrs	. last birthday)	If Under		If Under	24 Hrs. Min.	8. Date of Birth (Month, Day,			lace (State or Foreign
	Director		579-22-0449	1□M 212 F	80	Yrs.	Months	Days	Hours	MIII.	Aug. 30	1923		h., D.C.
	pu ,		Usuel Residence of Decedent		100.0	ity. Town or Lo	and an							Od Janida Ole Limite
	aryla shov	_	10a. State 10b. County		100.0	Ry, TOWN OF LC	Gation							0d. Inside City Limits 1 ☐ Yes 2 ☑ No
	Be-f	Director	MD	Calvert			101 7		kirk			0.000	4/1	
	with ti	Dir	10e. Street and Number				10f. Zip				16	g. Citizen of V	vnat Cour	itry ?
	s 23	ral	2895 Chaney Ro	Dad 12. Was Dece	dest Ever in I	16 12 1	Man Door de	207		min2 /Cn	ody Van ar Na	USA 14 Bac		ean Indian,
	ltem Item	nu	11. Marital Status	Armed Fo	rces?	J.S. 13.	If Yes, speci	fy Cubar	n, Mexican	n, Puerto	ecify Yes or No- Rican, etc.)		k, White,	
36	rs aff	by Funeral	1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced	ed 1 ☐ Yes If Yes, Giv Year or Di	e A		1 ☐ Yes 2	No 🏋	Specify:			Specify	whi	to
21215-0036	within 72 hours after death with the Maryland ene. than *neturel', or Items 23a or 28e-f show ha Madical Exerviller f-saal be muffied at	pa	15. Decedent			16a. Dece	dent's Usual	l Occupa	ition		1	6b. Kind of Bu		
5	n n	plet	(Specify only highes	t grade completed)	4075.\	(Give	kind of work DO NOT use	k done d e retired)	luring mosi)	t of worki	ng			•
72	with jiene r tha	Completed	Elementary/Secondary (0-12)	College (1	-401 5+)	sec	retary	v				public	sch	ools
	illed Hygi other	Be C	17. Father's Name (First, Middle, I	.ast)				_	18. Mothe	er's Name	(First, Middle, M			
<u>ھ</u>	lid be lental rked o	To B	Murphy Cli:	fton s	Suthard	Ē			Gra	ace	Louis	ie.	Gill	ions
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importement of Health and Mental Hygiene. Importement if item 27 is marked other than "neturel", or Items 23a or 28e-1 show any injury or other treumatic event, the Madical Experiment static by multiple any injury or other treumatic event, the Madical Experiment static by multiple any injury or other treumatics.		19a. Informant's Name/Relationsh				ng Address	(Street a			I Route Number,			
	and 2 ealth a n 27 is		Ernest Hillian	rd, husba	and	2895	Chane	ev R	oad.	Dunk	irk, MD	20754		
ē,	f Hez		20a. Method of Disposition			Place of Dispo	sition (Nam	e of	1			0c. Location -		own, State
Baltimore,	Pages nent of J ant: If its ary or o		1 ☑ Burial 2 ☐ Cremation 1 ☑ Donation 5 ☐ Other (St		State	. Memo				3_05	5_04	Dunkir	le M	20754
薑	permit. I Departm Importer any inju		21. Signature of Fungal Service I			-	2. Name and		-		-04	Duikir	K. 1.7	2 20/54
ä	Departiment Department		William	K. Th	673	R	ausch	Fune	eral	Home	P.A.,	Owing	s. M	20736
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н	Examiner		Samuelally let avviltime	ьV	entri	mor	gry	hyt	40001	Q A	ND Care	liac An	01+4	days
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	ecute ind trans	аш	Cause (Disease or injury that initiated events resulting in death) Last	a. Ath	705C	1670ti	c (g	rds	O Va	escu	lan d	SECES	0	
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9	leath certitica attending ph I for use as th	Physician/Med	IF FEMALE:											
Box	ath ce ttend or us	lan/	23b. Was decedent pregnant in the past 12 months?		irth 2 ☐ Fet	al death 3□	Ectopic pre					23d. Dat	e of delive nth	ry Day Year
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P.O.	that the de ned by the a detached f	Æ	Part II. Other significent condition	ne contributing to de	ath hut not so	culting in the u	ndorh ing na		n in Bod I		23a Did tab	acco use cont	ribute to th	ne cause of death?
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Records,	w require been si should I	ted									1 10.	20140	оцию	ably 4 Gonkholm
9	law nasb	nple									24a. Was an autopsy	ļ ŗ	prior to con	psy findings available mpletion of cause of
<u>~</u>		Completed									perform		leath?	2□ No
of Vital	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner?	lta-vital.	/			01		of Death	(Check only one)		
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ū	ing P	on:	27. Manner of Death 1 ☑Natural 5 ☑ Pending	28a. Date of (Mont	of Injury h, Day Year)	28b. Time of Injury		Bc. Injury Work			28d. Describe how	v injury occurr	ed	
Sio	Attending ir death. sctor: Atlei by the tune	cat	2 Accident investig	ation			М		′es 2 🗆 I					
Division	E Sign	Certification:	4 Homicide determi	ned Zoe. Flace	of Injury - At I ng, etc. <i>(Spec</i>	nome, farm, str ify)	eet, factory,	, office			28f. Location (Str. City or Town,		er or Rura	l Route Number,
	Hospitel 24 hours a Funeral tely tilled		29a. Certifier 1 Cartifyin	g Physicien: To the	best of my kn	owledge, deati	n occurred a	at the tim	e, date an	d place, a	and due to the car	use(s) and ma	nner as si	ated.
	To the Hospitel within 24 hours a To the Funeral I completely tilled	Medical		Examiner: On the ba										
	To the within To the Comp	ž	29b. Signature and title of sertifier		7/1/	Ma	29c.	License		ニ つ	29	d. Date signed	(Month,	Day, Year)
)	-		Lega	C. C (WIG	114	1	U 5	065	23		3/2/	04	
	,		30. Name and address of person	who completed caus	e of death (Ite	m 23a) (Type,	Print)	YA	W.	6	SURAN	1A	,	
	6		5851. D	eale ch	word.	ton	Ruc	101	_ カ	ecel	e mD	20	75	/
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	Registr	ar	MAR	0 8 2004	Blow	es th	Gos	the said	8					

			1 = For State Registrar	State of	Marylan	-		nt of H te of L		ınd M	ental Hyç	giene leg. No. 20	04	08946
			1. Decedent's Name (First, Middle, Las	t)							2. Date of Dea Month	ith Day	Year	3. Time of Death
	Physici /Medio		James Thomas Hu	tcheson							March		004	0500 ^M
	Examir		4e. Fecility Name (If not institution, give	street and num	ber)		4b. City	. Town, or	Location o	f Death		4c. County	of Death	
			103 Brookview Cou						inste:		0.0		arrol	
Ĺ	Funeral		5. Social Security Number 6. S	ex DXM 2□F	7. Age (In yrs.	73 Yrs.	Months	Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day	(, Year)	9. Birthp	
	Director		173-22-3212 Supply Supp			/3					May 0	0 1930		PA_
	/land		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation						1	0d. Inside City Limits
	Man	tor	MD Carr	oll		Westr	ninst	er						1X Yes 2 No
	on the	irec	10e. Street and Number				10f. Z	p Code				10g. Citizen of V	Vhat Cour	ntry?
	th wil	al	103 Brookview Co	urt				213				USA		
	teme	Funeral Director	11. Marital Status	12. Was Dece Armed For	ces?	l.S. 13.	Was Deci If Yes, sp	edent of Hi ecity Cubai	spanic Orig n, Mexican	gin? (Spe , Puerto F	cify Yes or No- Rican, etc.)		e - Americ k, White,	can Indian, etc.
36	s afte	by F	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 □ Yes If Yes, Give Year or Da	9		1 🗆 Yes	2 No	Specify:			Specify	· Whi	.te
21215-0036	within 72 hours after death with the Maryland ane. than "netural", or Iteme 23a or 28a-f show the Medical Exercitive for colline a	ed t	15. Decedent's Ed			16a. Dece	dent's Us	Jal Occupa	ation			16b. Kind of Bu	siness/In	dustry
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Maryland	2 short and and le m	1	19a. Informant's Name/Relationship (1 81.6			. 358			r, City or Town,	State, Zip	Code)
_	1 and 1eaith im 27 ther to		James C. Hutcheso 20a. Method of Disposition	n/son	20b. F	4350 Place of Dispo		e Roa	d Wa		nster,	MD 211 20c. Location -		wn. State
ŏ	Peges nent of H ont: If its		Burial 2 Cremation 3		State	cemetery, crei	matory or	other place	1	2/0/	20004			
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۵.	that the by detact	h h	Part II. Other significant conditions of	ontributing to de	ath but not res	sulting in the u	nderlying	cause give	en in Part I.		23e. Did to	bacco use conti	bute to th	e cause of death?
ds,	uires sign	d by	Coverney art	ern d	بمعم	4					1 🗆 🗸	es 2 No	3 🗌 Prob	ably 4 □Unknown
Vital Record	The law requir ate has been si page 2 should	Completed	Hyperienou	m							24a. Was a autop perfor	med?	rior to cor leath?	psy findings available inpletion of cause of
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of <	Physician: this certifical	70	1 Yes 2 Mo		npatient 2	ER/Outpatier	nt 3 🗆 🗈		4 🗆 Nui	rsing Hom	ne 5 Resid	ence 6 Oth	er (Specify	/)
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Division	To the Hospitel or Attending Phyeicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	Certification;	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	289. Place	of Injury - At h ig, etc. (Special	iome, farm, sti fy)	reet, lacto	ry, office		2	8I. Location (S City or Tow		er or Rura	l Route Number,
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	edical	29a. Certifier 1 ☐ Certifying Ph (Check only one) 2 ☐ Medicel Exar	ysicien: To the niner: On the ba and mann	sis of examina	owledge, deat ation and/or in	h occurre vestigatio	d at the tim n, in my op	ne, date and pinion, deat	d place, a th occurre	nd due to the d ad at the time, d	ause(s) and ma late and place,	nner as st and due to	ated. the cause(s)
	To the To the Comp	M	29b. Signature and title of certifier				2	c. License	number			29d. Date signed	(Month,	Dey, Year)
7	WILL		P Embo 1	1	\angle			00		076		318	14	
	Mass		30. Name and address of person who	ndoza	of death (Ite	m 23a) (Type,	Print) P	de				nster	MA	21157
	Sta Regist		31. Date liled (Month, Day, Year)	32. R	egistrar's Signa	ature	1							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2004 2. Date of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 2004 **Physician** MARCH 1, STANLEY RAY HOLLINGER 8:08 PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Deeth 4b. City. Town, or Location of Death Examiner CARROLL HOSPITAL CENTER WESTMINSTER CARROLL 6. Sex If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Director 215-26-8919 73 14, 1930 WASHINGTON, DC Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1√X es 2 □ No Directo MARYLAND CARROLL WESTMINSTER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 25 FITZHUGH AVENUE 21157 UNITED STATES by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PRESIDENT AUTOMOTIVE DEALERSHIP 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be should be f nd Mental I 2 KENNETH RAY HOLLINGER NANCY KATHERINE HAMON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is m any injury or other traum once. 25 FITZHUGH AVENUE, WESTMINSTER, MD M. JOAN R. HOLLINGER/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Gremation 3 Removal from State
4 Donation 5 Other (Specify) CARROLL CREMATION 3/4/2004 HAMPSTEAD, MARYLAND 22. Name and Address of Facility
MYERS-DURBORAW FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee Kolut IVh 91 WILLIS STREET, WESTMINSTER, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Due to (or as a consequence of): Interction /Medical Examiner coronary artery disease Atheroscle with Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last YECH'S burial-transit be executed and Due to (or as a consequence of) Box 68760, the attending physicien Physician/Medical as the IF FEMALE esn 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? Year Month 4☐Pregnant at time of death 5 Other (specify) signed by the all d be detached for ☐Yes 2☐No P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 1D Yes 2 No 25. Was case referred to medical examine 1 Fig. 8 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 2 PER/Outpatient 3 DOA this funeral 27. Manne of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Matural 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 2 Accident after death Director: in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled i within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 124 and manner stated. ţ 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D43453 March 3, 2004 completed cause of death (Item 23a) (Type, Print) 30. Name and address of passon who Memorial Ave Westminster Mis V. DIXON 200 MD 32. Registar's Signature 31. Date filed (Month, Day, Year) State Registrar 2004

Hatfi	el		se Type or State o	of Marylan	d / Depa		of He	ealth a		_	ygiene 🕺	00	4 0891
Physicia /Medica		1. Decedent's Name (First, Middle		atfield						2. Date of D Month March	eath Day 1 2004	Year	3. Time of Death 1155 a
Examine	-	4a. FCARROLL 1.0 HOSTA Carroll Count	y General	. Hospita		W	estr	ninst	er		Car	roll	
Funeral Director		5. Social Security Number 218-32-8268 Usual Residence of Decedent	6. Sex ★★ 2 F	7. Age (In yrs. 6	- /	If Under 1 Months	Days	If Under 2 Hours	Min.	8. Date of Bi (Month, D Feb. 2	4, 1937	9. Birt Co Ma	hplace (State or Forei untry) ryland
Ba-f show	ctor	MD County Carro	11	10c. City	y, Town or Lo Westm								10d. Inside City Limi 1 X Yes 2 ☐ N
De no	Dire	10e. Street and Number				10f. Zip C					10g. Citizen o		untry?
if Health and Mental Hygiene, lean 27 is marked other than "natural", or itams 23e or 28e-f show other traumatic event, it a Medical Examiner must be notified at	d by Funeral Director	66 Carroll St. 11. Marital Status 1 Never Married 2 Marr 3 Widowed 4 Divorced	12. Was Dec	2 MNo ive	- 1	1		spanic Orig i, Mexican, Specify:	in? (Spec Puerto R	cify Yes or Nican, etc.)	U.S. 14. Ri Bi	ace - Ame ack, White	ncan Indian, a, etc.
Hygiene. ither than "natu int, it e Miglical	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	College ((1-4or 5+)	(Give	lent's Usual kind of work DO NOT use	done du retired)	uring most			16b. Kind of Manu	factı	·
nd Mental H marked oth umatic evan	To Be	17. Father's Name (First, Middle, Charles Melvin I	Hatfield					Anna	a Eli	zabet	e, Maiden Suma h Stult	z	
alth and n 27 is mais trauma		19a. Informant's Name/Relations! Wayne Hatfield			630 W	lindy	Hi 11		, Wes	tmins	ter, MD		
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Department of Important: If i any injury or once.		21. Signature of Funeral Service	Licencee Lac	Ban		Name and O Chu			110		r Funer		
.0 =	cai Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. — Due to	(or as a consequence of the cons	uence of):	riste	nt	vi (a	reli	01/654	le-Di	,3le	Onset and Death
by the attending phy tached for use as th	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live I	itcome of pregnal birth 2 Fetel nant at time of de lown	death 3	Ectopic preg Other (spec						ate of deli	very Day Year
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page 2	Be Completed	25. Was case referred to medical	-Pe-n					26 Place	of Death		psy ormed? 2 \(\text{No} \)	Were autorior to death?	opsy findings available ompletion of cause of
this la	9	examiner? 1 Yes 2 No 27. Manner of Death Natural 5 Pending	g 28a. Date (Mon		ER/Outpatient 28b. Time of Injury	280	Other Injury a Work?	4 □ Nurs	sing Home	e 5⊡Resi	idence 6 00 how injury occu		ify)
after death Director: ,	Certification:	2 Accident investig 3 Suicide 6 Could r 4 Homicide determi	not be 28e. Place	e of Injury - At ho ing, etc. <i>(Specify</i>	ome, farm, stre	M et, factory, o		es 2□N			Street and Num wn, State)	ber or Ru	ral Route Number,
	Medical C	29a. Certifier 1 Certifyin (Check only 22 Medicel I	g Physician: To the Exeminer: On the b and man	e best of my know easis of examinat oner stated.	wledge, death lion and/or inv	occurred at estigation, in	the time my opir	, date and nion, death	place, an	nd due to the	cause(s) and m	anner as and due	stated. to the cause(s)
		29b. Signature and other of certifier				29c. l	OCM				29d. Date sign March		
W3378		30. Name and address of person of	who completed cause	se of death (Item	23a) (Type, I	Print) 111	Pe	nn St	reet	, Balt	imore,	Mary	land 21

Registrar

MAR 0 4 2004

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene For State Ragistrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 57 М chruar 2004 James Lawrence Hamilton /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Washington

9. Birthplace (State or Foreign Country) Hagerstown If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days 1**⊠**M 2□F Months 80 March 21,1923 West Virginia Director 235**-14**-6271 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f show avent, the Medical Exercit at must be putified at 1 ☐ Yes XXNo Maryland Washington Hagerstown, Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 18807 Dover Drive 21742 Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 0. Specify: White 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done du life. DO NOT use retired) ring most of working College (1-4or 5+) Elementary/Secondary (0-12) Chemical Engineer Chemical Company f Health and Mental Hygi Item 27 is marked other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Dale Hunt Hamilton Carla Yorgensen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Nancy Pugh Hamilton/Wife 18807 Dover Drive Hagerstown, Maryland 21742 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition permit. Pages 1 Department of H Important: If Ite any injury or oti 1 ☐ Burial 2 IS Cremation 3 ☐ Removal from State Smithsburg Crematory Mar. 2, 04 Smithsburg, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee 1331 Eastern Blvd. N. Hagerstown, Maryland 21742 Hucla 23a. Part1. Enter the distise, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** rechi disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown p 23e. Did tobacco use contribute to the cause of death? signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ pe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 1 Yes certificate 2 No C word or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 3 DOA Certification: To 1 Unpatient 2 ER/Outpatient this 28a. Date of Injury (Month, Day Year) funeral 28c. injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after death illed in by the 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ill 11110 i 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

		1 - For State Registrar	State of Marylar		artment rtificate				Reg.	ne No. 20	04	089	50
Physic /Med	lical	Decedent's Name (First, Middle, Last Anna Mae HARDEN 4e. Fecility Name (If not institution, give)			4b. City. T	own, or l	ocation of I	Mon		Day		3. Time of De	A M
Exam Funera		Washington County 5. Social Security Number 6. Se	Hospital x 7. Age (In yrs.	last birthday)	If Under 1	lage1	stown	Hrs. 8 Date	of Birth	W	ashir	ngton	oreign
Directo		216-30-7224 Usual Residence of Decedent 10a. State 10b. County	M 2⊠F 76	Yrs.		Days	Hours	Sept	t. 8, 19	927		ece (Stete or Fo try) yland Od. Inside City L	
th the Maryl or 28a-f sho	Director	Maryland Washi	ngton	Hage	rstowr 10f. Zip C				10g.	Citizen of W	hat Count	1 [XYes 2 [□ No
Z1Z13-UU36 4 within 72 hours after death with the Maryland piene. r than "natural", or itams 23s or 28s-f show the Madical Evanther must be notified at	by Funeral Director	335 N. Locust Str 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	eet 12. Was Decedent Ever in U Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:					n? (Specify Yes Puerto Rican, e	or No-		- America		
215-UU36 thin 72 hours aff e. an "natural", or	Completed b	15. Decedent's Edu (Specify only highest grad	ication	16a. Deced (Give life. L	dent's Usual kind of work DO NOT use	Occupat done du retired)	ion ring most o	f working	166	. Kind of Bus	siness/Ind	ustry	Place Solidar Share Share SHIRE THE
DG Siles tal Hyg	Be	17. Father's Name (First, Middle, Last) Robert Lee Eaton,	0	home	maker	1		Name (First, M		den Sumame	own)		
Mar nd 2 sh ulth and 27 is m	2	19a. Informant's Name/Relationship (T) Elizabeth Connoll	vpe, Print)				d Number o	or Rural Route	Number, Ci	ty or Town, S			40
S 1		20a. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ F '4 □ Donation 5 □ Other (Specify)	Removal from State	Place of Dispo cemetery, cren airvie	natory or oth	er place)		Date 5/8/04		Location - C		wm. State	Land
Baltimo permit. Page Department of Important: if eny injury or		21. Signature of Feneral Service Licens	W/ Yourse	a la		Wi1	son B	lvd., E	lagers	NERAL town,	Md.	21740	
Physiciar /Medica Examine	1	23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)	ne cause on each line. Due to (or as e consec	lascu			43		tory arrest,			Approximate Interval Betwee Onset and Dear	
OX 68 / 60, certificate be executed ding physician and ise as the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect.										
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death death death d for u	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 140 9 Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c 9 ☐ Unknown	Ideath 3	Ectopic pred Other (spec					23d. Date Mon	of deliver	y Day Year	r
ecords, P.O. law requires that the as been signed by th 2 should be detache	b	Part II. Other significant conditions co	ntributing to death but not res	ulting in the ur	nderlying cau	ise given	in Part I.	239				e cause of death	
The ate h	Completed							10		? pr	for to comeath?	sy findings avai pletion of cause 2 No	ilable e of
OB	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Impatient 2	ER/Outpatien	nt 3□ DOA	Other		Death (Checking Home 5		6 ∏Othe	(Specific)		
SING Fing	<u> - </u>	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yeer)	28b. Time of Injury		c. Injury a Work?		28d. Des		njury occurre			
5 g # 5 E	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	y)				City	or Town, St	ate)		Route Number,	
To the Hospitel or within 24 hours afte To the Funeral Discompletely filled in	Medical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exemi	sician: To the best of my kno ner: On the basis of examina and manner stated.	tion and/or inv	vestigation, i	the time n my opir License r	nion, death	place, and due to occurred at the	time, date	e(s) and man and place, ar Date signed	nd due to t	the cause(s)	
		Day-	(- 00at 7				NE.	3-	-5-	2006	, , , sai,	
Elk, 7		30. Name and address of person who come address of person who come and address of person who come add	ompleted cause of death (Iter 1260, 410 - 32. Registrar's Signa	1282	-1 _ O	AIC	1411	NE.	HAG	ERST	CONN	· MD	
S	tate	MAR US 20	U4 Secure	D. 190	retel								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2004 08951 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 2115 HARVEY EUGENE JEWELL 02 23 2004 /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 6136 FLORENCE STREET WICOMICO SALISBURY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 ★M 2 □ F VIRGINIA Director 227-21-0038 40 06-30-1963 Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show in than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Directo WICOMICO SALISBURY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6136 FLORENCE STREET 21804 Pages 1 and 2 should be filed within 72 hours after death Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🕅 No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√ No þ Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) OPERATOR HEAVY MACHINERY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be fits Department of Health and Mental Hy Important: If Item 27 Is marked oth any injury or other traumatic event <u>once.</u> HARVEY E. JEWELL, SR. TRACY RAGLAND 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHRISTINE HERRELL - SISTER 1406 LAKEFRONT DRIVE, CAIRO, GEORGIA, 39828 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) CREMATORY OF DELMARVA 2-26-2004 DELMAR, DELAWARE 22. Name and Address of Facility BOUNDS FUNERAL HOME, INC. 21. Signature of Funeral Service Licensee 705 EAST MAIN STREET, SALISBURY, MARYLAND 21804 2011 23a Part 1. Enter the disease in plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** self inflicted gunshot wound to head /Medical Examiner Sequentially list conditions, if any, leading to immediate raise. First line that Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physicien and for use as the burial-trar Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ► Mo 24a. Was an certificate has birector, page 2 s autopsy performed 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ■ Yes 2 □ No ၀ 1 | Inpatient 2 | ER/Outpatient 3 | DOA this 28a. Date of Injury (Month, Day Year) 2 23 04 Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Injury death. 1 ☐ Yes 2 No GSW head investigation 2100 2 Accident hours after deat ineral Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide nome Salisbury 24 hours a 1 ritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier within 24 ho To the Fune completely fi (Check only one) 29b. Signature at title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of per n who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

Carroll

5 2004

FEB 2

31. Date filed (Month, Day, Year)

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 200 ι_{ι} For State Registral Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** dward Month Day sarmon 5:50a^M Y 20, 2004 4c. County of Death FEBRUARY /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death burlin Berlin If Under 1 Year If Under 24 Hrs. NUISING Norecester 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** Months 10M 20F Days Hours Mar 1, 1916 219-07-7251 Yrs Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location and Mental Hygiene. is marked other than "natural", or Items 23a or 28a-f show 10d. Inside City Limits traumatic event, the Madical Examiner must be notified at 1 1 Yes 2 No Completed by Funeral Director SUSSEX Millsboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? P.O. 896 9966 filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ Mo If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Plack 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Laborer NURSERU permit. Pages 1 and 2 should be flit Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 900. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Jamon Luvenia Dennis Usaac 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f.O. BOX 894 Millsboro, Lou Brende Showell daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Deurial 2 ☐ Cremation 3 ☐ Removal from State 2-28-04 `4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens Funeral Horse 22. Name and Address of Facility Lewys 1618 Wax West Famil. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ardiovescular scherotre Physician /Medical Due to (or as a consequence of) Examiner 12600 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine anding physician and use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Doknown 1 ☐ Yes 2 ☐ No 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2V5 No 1 ☐ Yes 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: Certification; To 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) 03 aste Bosolula 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 0 2 2004

Registrar

EDWARD

JARMON,

-		State of Maryland / Department of Health and M Certificate of Death	Reg. No. 2004 08953
	Physician	1. Decedent's Name (First, Middle, Last)	2. Date of Deeth 3. Time of Death Month Day Year
-	/Medical	LEAH MARIE LARSON 4a Ferility Name (If not institution give street and number) 4b. City, Town, or Lo	Feb. 27, 2004 7:47 AM
	Examiner	the country state of the count	is obtainy of booking
	Funeral		
	Director	473-20-1595 1 M 2 T/F 88 Yrs. Months Deys Hours Min.	10-14-1915 MARSHALL, MINN.
	D	Usuel Residence of Decedent	
	aryler show	10a. Stete 10b. County 10c. City, Town or Location	10d. Inside City Limits
	Sa-f	MD WICOMICO SALISBURY	1 ☐ Yes 2X No
	Mith th	10e. Street end Number 10f. Zip Code	10g. Citizen of Whet Country?
	within 72 hours after death with the Marylend ene. than "naturat", or items 23a or 28a-f show he Medical Examiner must be notified at simplefted by Funeral Director	218 PHILLIP MORRIS DRIVE 21801 11. Merital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Spe	USA ecify Yes or No- 14. Race - American Indian,
	ter d	Armed Forces? If Yes, specify Cuban, Mexican, Puerto	Rican, etc.) Black, White, etc.
050	ors af	1 Never Merried 2 Married 1 Yes 2 No If Yes, Give 1 Yes 2 No Specify: 3 Widowed 4 Divorced Yeer or Dates:	Specify: WHITE
9	2 hot	15. Decedent's Education 16a. Decedent's Usual Occupation	16b. Kind of Business/Industry
215	led within 72 ho lygiene. her than "natura nt, the Medicell Completed	(Specify only highest grede completed) (Give kind of work done during most of workii Elementary/Secondary (0-12) College (1-4or 5+) (Give kind of work done during most of workii	ing
LEAH nd 21	er th	9 HOMEMAKER	OWN HOME
	d oth	17. Father's Neme (First, Middle, Last)	e (First, Middle, Maiden Surname)
s S	Meni Meni Meni Meni Meni Meni Meni Meni		NE LAPLANTE
LARSON, LEAH re, Maryland 21215-0020	12 sh h end h end is rr traun	19a. Informant's Name/Relationship (<i>Type, Print</i>) 19b. Mailing Address (<i>Street and Number or Rure</i> 2.2.4. CEDAD, DRIVER, CALLED	
	Health	LINDA GOLDWIRE - DAUGHTER 336 CEDAR DRIVE, SALISB 20a. Method of Disposition 20b. Place of Disposition (Name of	Date 20c. Location - City or Town, State
LA Baltimore,	permit. Peges 1 end 2 should be filed within 72 hours after death with the Marylen Department of Health end Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23e or 23e-f show any injury or other traumatic event, the Madical Examiner must be notified at once. To Be Completed by Funeral Director	1 ☐ Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place)	
臣	it. Purture	Of Circolary of Francis Consider Licenses	3-2-04 SALISBURY, MARYLAND
Ba	permi Depare Impo any ir once.	BOU	INDS FUNERAL HOME, INC.
		705 EAST MAIN STREE 234. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac o shock, or heart failed a List only one cause on each line.	T, SALISBURY, MARYLAND 21804 or respiratory arrest, Approximate
x 68760,	sertificate be executed ding physician end ding physician end se es the buriel-transit	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	LVRE I YA.
Bo	ettenc for us		
o,	y the check	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did tobacco use contribute to the cause of death?
0	that hed by dete	EMPHYJEMO	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown
Division of Vital Records, P.O. Box	To the Hospital or Attending Physician: The law requires that the death certif within 24 hours effer death. To the Funeral Director: Affer this certificate has been signed by the ettending completely filled in by the funeral director, page 2 should be deteched for use er. Medical Certification: To Be Completed by Physician/Mk.		24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
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ita	rtifice	25. Was case referred to medical examiner? 26. Place of Death	(Check only one)
>	nystcl lis ce direc	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Hor	me 5 Residence 6 Other (Specify)
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Sio	eath. or: A the fu	2 Accident investigation M 1 Yes 2 No	
Ξ	or Att	4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)
	To the Hospital or Attending Physician: within 24 hours effer death. To the Funeral Director: Affer this certific completely filled in by the funeral director. Medical Certification: To Be	29a. Certifier (Check only (Check only 2) Madical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred	and due to the cause(s) and manner as stated. ed at the time, date and place, and due to the cause(s)
	thin 2, the Find plet	one) end manner stated. 29b. Signature and title of certifier 29c. License number	29d. Date signed (Month, Day, Year)
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			12.107
3 DG	?		St.Suite, Salisbury, Md.21804
	State Registrar	31. Dete filed (March Pay Year) 2004 32. Registrer's Signature & Sports	

DHMH 16 Rav 6/95

State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 200 Month MINOR **Physician** 0406 DEBORAH LEE LINKINS /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** ugger MAr bors
If Under 1 Year If Under 24 Hrs. 6 evers 83 Joyceton Terrace vince 8. Date of Birth Month Day, Ye 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex **Funeral** Months Days Hours Min. 1 □ M 2 🙀 F NEW YORK 50 577-72-5663 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10b. County 10c. City, Town or Location ral, or items 23s or 28s-f show Examiner must be notified at 1 ☐ Yes 2 No MARYLAND PRINCE GEORGES UPPER MARLBORO Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number UNITED STATES 83 JOYCETON TERRACE 20774 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 25 No If Yes. Give 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married 1 ☐ Yes X No Specify: Specify: BLACK by 3 ☐ Widowed 4 ☐ Divorced "natural" Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12TH GRADE then College (1-4or 5+) RECEPTIONIST INSURANCE 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Health and Mental Hem 27 Is marked oth HELEN MARIE LINKINS MILES CLARK 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) If item 27 la 83 JOYCETON TERRACE, UPPER MARLBORO, MARYLAND 20774 HELEN M. LINKINS / MOTHER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of Hi
Important: If iter
sny injury or oth 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State ST. CHARLES CEMETERY MARCH 10, 2004 GLYMONT, MARYLAND * 4 ☐ Donation 5 ☐ Other (Specify) 21. Singature of Funeral Service rice has been MOO583 THORNION FUNERAL HOME, P.A.

3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Atheroscierotic Cardiovascular Heart Disease Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the attending physician and hed for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 donknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has autopsy performed 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Yes 2 No Medical Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred After or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide hours after within 24 hours a 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Munc 10, 2004 HOOSS 927 30. Name and address of person with completed cause of death (Item 23a) (Type, Print) Chevely Mung latered 3001 Hospital 32. Registrar's Signature State 2004 Registrar

			- For	State of Man	/land / Depa	artment of	Health and		iene	
			1 - State Registrar		Cei	rtificate of	Death	R	og. No. 2004 0895	5.5
	Physici /Medi		1. Decedent's Name (First, Middle, Last James Jacob LIGHT					2. Date of Deat Month	Day Year 0 Z, 2004 0512 A	
	Examir		4a. Facility Name (If not institution, give			4b. City, Town,	or Location of Dea	ith	4c. County of Death	
	*		Washington County 5. Social Security Number 6. Se		n yrs. last birthday)	Hag If Under 1 Year	gerstown	S O Date of Birth	Washington	<u>.</u>
	Funeral Director			M 2□F 80	Yrs.	Months Days			Year) 9. Birthplace (State or Fore Country) 1923 Maryland	iign
	/land		10a. State 10b. County	10	c. City, Town or Lo	cation			10d. Inside City Lim	its
	Maries	tor	Maryland Washi	ngton		Hagersto	own		1 ☐ Yes 2 ∑ 1	No
	or 28	Director	10e. Street and Number			10f. Zip Code		10	Og. Citizen of What Country?	
	s 23a		315 Emmert Road				21740		USA	
936	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or items 23a or 28a-1 show event, the Medical Examinar must be motified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ॲ Widowed 4 □ Divorced	12. Was Decedent Eve Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates:		Was Decedent of I f Yes, specify Cub 1 ☐ Yes 2 🖾 No		Specify Yes or No- rto Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: white	
Maryland 21215-0036	within 72 horens. ene. then *neture the Medical is	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed) College (1-4or 5+)	(Give	dent's Usual Occu kind of work done DO NOT use retire	during most of we	orking	16b. Kind of Business/Industry	
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<u>y</u> la	should the should the should the should the should be sh	To.	John Lightner					erine Laym		
Mai	0 0 0		19a. Informant's Name/Relationship (T) Doris Butler - nie	•					City or Town, State, Zip Code) Stown, Md. 21740	
	of Health item 27 other tr	i s	20a. Method of Disposition		Ob. Place of Dispo	sition (Name of			20c. Location - City or Town, State	
Baltimore,	Pages nent of I int: If its iry or o		1X Burial 2 ☐ Cremation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	Cedar Lav	natory or other pla vn Mem. 1		/5/04	Hagerstown, Marylan	d
alti.	arth ports inje		21. Signature of Funeral Service Licens	99		. Name and Addre	1		FUNERAL HOME	
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760,	Physician /Medical Examiner popularitansit popularitansit	cal Examiner	23a. Pent1. Enter the disease, or compleshock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	espiratonsequence of): sclereli insequence of):	e Card	ilure lio Vasc	Hypots ulay Di	Souse Approximate Interval Between Onset and Beath	
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of Vital Records,	The law recate has bee page 2 shou	Completed by	desandingone	sipmoid c		_	Failure	24a. Was an autopsy perform	prior to completion of cause of death?	
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of	Physi this c	2	1 ☐ Yes 2 No 27. Manner of Death		2 ER/Outpatien	3 DOA			nce 6 Other (Specify)	
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Division	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, stre pecify)		163 2 110	28f. Location (Str. City or Town,	eet and Number or Rural Route Number, State)	_
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	To the within To the comp	ž	29b. Signature and title of certifier			29c. Licens		29	d. Date signed (Month, Day, Year)	
7	_d D				MD	D 18	127	an an	3/4/04	
5	Y		30. Name and address of person who co	mpleted cause of death	(Item 23a) (Type, I	+ Hape	Steller.	md >	1740	
	Sta Registr		31. Date filed (Month, Day, Year) NAR 0.5. 26	32. Registrar's	Signature	radio		6		

			For State Registrar	State of Maryland	/ Department Certificate	of Health and I of Death		ene 2004	08956
			Decedent's Name (First, Middle, Last)		. ^		2. Date of Death		3. Time of Death
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	/Medic Examir	- 4	4a. Facility Name (If not institution, give str			Town, or Location of Deatl		4c. County of Death	
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	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last		1 Year If Under 24 Hrs.	8. Date of Birth	0.0:-	lace (State or Foreign try)
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	lter de	Š	11. Marital Status 12 Never Married 2 Married 12	Armed Forces?	If Yes, speci	fy Cuban, Mexican, Puerl	o Rican, etc.)	Black, White,	
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ore	of He	11 8	20a. Method of Disposition 1 ☑ Burial 2 ☑ Cremation 3 ☐ Re	com	e of Disposition (Nameletery, crematory or of	her place)	Date 2	0c. Location - City or To	
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alt	permit. Departr Importa any inj	0	21. Signature A Edneral Service Licenses	/	22. Name and	Address of Facility		SMITH FI	H
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45			23a. Part1. Enter the disease, or complice shock, or heart ailure. List only one	ations that caused the death.	Do not enter the mode	of dying, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death
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Division	Attending in death. ector: After by the funer	tio	1 XNatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury M	Work? 1 ☐ Yes 2 ☐ No			
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	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	edical	(Check only 2 Medical Examination one)	er: On the basis of examination and manner stated.	n and/or investigation,	in my opinion, death occi	irred at the time, dai	e and place, and due to	the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier			License number		d. Date signed (Month, i	Day, Year)
			16		$ \mathcal{I} $	58182	_ 2	2-27-	$\mathcal{O}(\mathcal{G})$
			30. Name and address of person who con	npleted cause of death (Item 2	3a) (Type, Print)		,		
				orge 8118 (rood Lu	ek Road L	anham,	maryland	
		ate	31. Date filed (Month, Day, Year)	32. Registrar's Signatur	" 4 Ann	ek Road L		J	
	Regist	rar	MAR 0 2 2004	1 per	and a				

DHMH 17 Rev 1/2001

Moore, Annie

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	•	1 → For State Registrar	State of Mary		Certificate of			21	004 089				
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Physicia		A alicin T		. /			Month	Day	Year 0840				
/Medic		4a. Fecility Name (If not institution, give	Mass e	7-	4b. City. Town.	or Location of Death	1.	4c. County					
Examin	er	A	ssing + Reh	1- 600	50	lisbur	· V	1 1	lomico				
Funeral		5. Social Security Number 6. Se	7. Age (In	yrs. last birth	day) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day		9. Birthplace (State or Fo				
Director		214-16-4954	^{2 M 2 □ F} 83	Yt	s. Months Days	Hours Min.	February		Maryland				
		Usual Residence of Decedent		60 T									
it of Health and Mental Hygiene. If item 27 is marked other than "naturel", or Items 23a or 28a-1 show or other traumatic event, the Medical Examinar must be notified at	<u>.</u>	10a. State 10b. County		. City, Town					10d. Inside City L 1 XYes 2				
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Dan Dan	- E	10e. Street and Number 105 Times Squar			10f. Zip Code 2180	^1		0g. Citizen of V					
18 23 Thus	Funeral Director		12. Was Decedent Ever	in II S			actu Vac or No-	14 Rac	USA e - American Indian,				
Item	ij.	11. Marital Status 1 Never Married	Armed Forces?		 Was Decedent of F If Yes, specify Cub 	an, Mexican, Puerto	Rican, etc.)		ck, White, etc.				
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nd Ment marked umatic e	To I	Clinton John Mas	ssey			Wilsie	Beauch	amp					
and le m		19a. Informant's Name/Relationship (T)			failing Address (Street								
eaith m 27 ner tr		Audrey K. Massey/			36079 Mt. 1		-		MD 21874				
If ite		20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐ F		cemetery.	isposition (Name of crematory or other pla	ce)			City or Town, State				
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		23a. Pert1. Enter the disease, or comp shock, or heart failure. List only o	ications that caused the one cause on each line.				or respiratory arr	est.	Approximate Interval Betwee Onset and Dear				
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death. ctor: After this certificate has y the funeral director, page 2	Certification: To Be	examiner? 1 Yes 2 No	28a. Date of Injury (Month, Day Yea 28e. Place of Injury - building, etc. (Sp sician: To the best of my iner: On the basis of exam	At home, farm	ny Mon 1 □ , street, factory, office leath occurred at the tirr investigation, in my d 29c. Licens	Yes 2 No	and due to the cared at the time, do	ause(s) and mai ate and place, a	nner as stated. Indidue to the cause(s) I (Month, Day, Year)				
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fler death. Director: After this certificate has in by the funeral director, page 2	edical Certification: To Be	examiner? 1 Yes 2 No	28a. Date of Injury (Month, Day Yea 28e. Place of Injury - I building, etc. (Sp sician: To the best of my iner: On the basis of exan and manner stated.	r) Inju	y Mon 1 □ , street, factory, office leath occurred at the limit or investigation, in my of the street of the st	Yes 2 No	and due to the cared at the time, do	ause(s) and mai ate and place, a	nner as stated. Indidue to the cause(s) I (Month, Day, Year)				

			1 - For State Registrar	ite of Maryland /		artment			d M		-	500F	N 2050
	Physic /Medi		Decedent's Name (First, Middle, Last) Hughie Thomas MOWBR.	ΑΥ						2. Date of De. Month March	ath	00.7	3. Time of Death
	Exami		4a. Facility Name (If not institution, give street and 785 S. Potomac Street S. Social Security Number 6. Sex	et			lagei	Location of D			4c. C	ounty of Death ashingt	
	Funeral Director		214-09-3781 Usual Residence of Decedent	7. Age (In yrs. last)	Yrs.	Months	Days	Hours A	Min.	8. Date of Birt (Month, Da Aug. 2,	v. Year)	9. Birthp Cour Vir	place (State or Foreign ntry) ginia
	death with the Maryland ma 23a or 28a-f show Imissi be notified at	ctor	10a. State 10b. County Maryland Washingto	on Ha		cation stown						10d. Inside City Limit 1 🖾 Yes 2 🗆 N	
	th with the 23a or 28	ai Director	10e. Street and Number 785 S. Potomac Street			10f. Zip	Code	21740			10g. Citize	on of What Cour	ntry?
920	after or Ite	by Funeral	1 ☐ Never Married 2 ☑ Married 1 ☐	s Decedent Ever in U.S. ned Forces?]Yes 2 XNo es, Give ar or Dates:	1	Vas Decede Yes, speci		panic Origin' , Mexican, Pi Specify:	? (Specuerto P	city Yes or No- lican, etc.)		. Race - Americ Black, White, pecify:	
Maryland 21215-0036	C1 65 UI	Completed	15. Decedent's Education (Specify only highest grade comp. Elementary/Secondary (0-12) Co	leted) 16 lege (1-4or 5+)	(Give I life. D	ent's Usuai kind of work OO NOT use pervi	done du retired)	ion uring most of	workin	g		of Business/Ind	
yland 2	s 1 and 2 should be filed within 7: f Heath and Mental Hygiene. item 27 is marked other than "n other traumatic event, the Medi	To Be C	17. Father's Name (First, Middle, Last) Arthur Lewis Mowbray					(Clau	(First, Middle, ıdia Ma	Maiden Su y Mor	umame) ris	
	1 and 2 sh Health and tem 27 is m		19a. Informant's Name/Relationship (Type, Pri- Helen Mowbray — wife 20a. Method of Disposition	1	85 S	.Poto	mac			rstown	, Md.	own, State, Zip 21740 tion - City or To	
Baltimore,	nit. Page artment o ortant: If injury or		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Euneral, Service Licensee	from State cemet	ery, crem	11 Ce	mete	ry 3	3/10	/04	Hage		Maryland
Ba	Depar Impor any ir		23a. Part1. Enter the disease, or complications shock, or heart failure. List only one caus	that caused the death. Do	41	5 E.W	ilso	n Blvd	l.,	Hagers	town,	Md. 21	
.8760,	Physician bhysician and bhysician and stream and stream is the burian-transit	dical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	ue to (or as a consequence	of):							1	Interval Between Onset and Death
P.O. Box 6	Physician: The law requires that the death certific this certificate has been signed by the attending p all director, page 2 should be detached for use as	Physician/Me	in the past 12 months?	is, outcome of pregnancy Live birth 2 □ Fetel deat Pregnant at time of deeth Unknown		Ectopic preg Other (s <i>pec</i>	nancy ify)				230	. Date of deliver Month	y Day Year
	w requires that been signed t should be deta	<u>م</u>	Part II. Other significant conditions contributin	g to death but not resulting	in the unc	derlying cau	se given	in Part I.					e cause of death?
Vital Records,	ian: The law requ tificate has been ctor, page 2 should	Completed								24a. Was an autops perform	У	prior to com death?	sy findings available pletion of cause of
f Vit	yaician us certi directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No Hospital:	1 ☐ Inpatient 2 ☐ ER/O	utpatient	3□ DOA	Other:			5 Reside		Other (Specify)	
Division of	ending sath. or: After ne fune		2 Accident investigation		Time of Injury	280 M	Injury at Work?			d. Describe ho			
Divis	Diff.	Certification:	4 nomicide	Place of Injury - At home, f building, etc. <i>(Specify)</i>						City or Town	, State)	umber or Rural	
	To the Hospital within 24 hours a To the Funeral completely filled	Medical		manner stated.	nd/or inve	stigation, in	my opin	ion, death oc	curred	at the time, da	ate and pla	ce, and due to t	he cause(s)
	5 4 5 6 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8		29b. Signature and title of certifier	cause of death (Item 23a) ATERIER 32. Registrar's Signature,		29c. L	cense n	D2	79	49	Mora	gned (Month, D.	ay, Year) 2004
*	34.		30. Name and address of person who completed DR. STEVEN H 31. Date filed (Month, Day, Year)	cause of death (Item 23a) ATLEBERG	(Type, Pr	rint)	Med	ical	Car	npus	Rel 1	tagers	town MP.
	Star Registra		MAR 0 9 2004	Sz. megistrar's Signature	B	ade							

State of Maryland / Department of Health and Mental Hygiene 2004 For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** ^{Day} 2004 Helen Rebecca MOWEN March 4, 5:05 p. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Beverly Health Care Hagerstown Washington If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Birthplace (State or Foreign Country) 1 ☐ M 2 🔀 F 92 Yrs 220-18-1041 Director April 27,1911 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 23a or 28a-f show 10d. Inside City Limits the Medical Examiner must be notified at 1X Yes 2 □ No Directo Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 750 Dual Highway 21740 USA Funera Items ? 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 2 1 No Specify: چ white 3₺ Widowed 4 Divorced "neturel", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 proofer 0 book publishers permit. Pages 1 and 2 should be file Department of Health and Menial Hy Important: If item 27 is marked oth eny jinty or other traumatic event size. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Roy Clinton Karn Edith Rebecca Stockslager 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clinton Mowen - son 4792 Pleasant Ridge Rd., Needmore, Pa. 17238 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Rest Haven Cemetery * 4 ☐ Donation 5 ☐ Other (Specify) 3/9/04 Hagerstown, Maryland 21. Signature of Funeral Service Licensee Nam and Address of Facility MINNICH FUNERAL HOME E. Wilson Blvd., Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Chebro vascullow 14ear /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sician and burial-transit or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): physician s the burial P.O. Box 68760. Certification: To Be Completed by Physician/Medical ding pl IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 反 Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? cate has l 200No 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 PNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation Natural within 24 hours after death, To the Funerel Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier To the h 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MANZAR. Hagestern SHAF 368 niell 31. Date filed (Month, Day, Year) NAR 08 32. Segistrar's Signature State Registrar

			1 - For State Registrar	State of M	larylan		artment <i>tificate</i>			and Mental Hy	ygiene Reg. No. 2	004	08960
	Physici /Medic	_	1. Decedent's Name (First, Middle, Last) Gladys Leoda							2. Date of D Month MARCH	04, 200	Day Year 11:00 ^P N	
	Examin		4a. Facility Name (If not institution, give str RAVENWOOD LUTHERA) 5. Social Security Number 6. Sex	N VILLA	GE	ast birthday)	4b. City, To HAGE If Under 1	RST(OWN If Under 2	24 Hrs. 8. Date of B	WASH	INGTOI 9. Birthp	lace (State or Foreign
q.	Funeral Director		219-12-1832 Usual Residence of Decedent	M 2⊠F	87	Yrs.		Days	Hours	Nov. 21	1916 1916	Mary	land
	Ba-f ehow	Director	Maryland Washingto	n	10c. City	y, Town or Lo Hag	erstow				10g. Citizen of		1 XYes 2 No
36	be filed within 72 hours after death with the Maryland that Hygiene. od other than "neturel", or items 23a or 28s-f show event, the Medical Examinar must be multised at	by Funeral Dir	1101 Corbett 11 Marital Status 1 Never Married 2 Marned 3 Notice 4 Divorced	Street Was Decedent Armed Forces I Yes, Give Year or Dates	?]No	'	217	740 Int of His by Cubar	spanic Orig n, Mexican Specify:	gin? (Specify Yes or N , Puerto Rican, etc.)	Unite	d Sta	tes can Indian,
21215-0036	within 72 hour iene. 'then "neturel' the Medical Ex	Completed b	15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)	ation		(Give life.	dent's Usual kind of work DO NOT use maker	done di	uring most	of working	16b. Kind of l	Business/Ind	
Maryland 2	should be filed nd Mental Hygi marked other umatic event, I	To Be Co	17. Father's Name (First, Middle, Last) Charles W. Phi							r's Name (First, Middle Katie Smi	ith		0.41
Baltimore, Mar	i and 2 shi fealth and im 27 is m ther treum		19a. Informant's Name/Relationship (Type Norma J. Peacher	e, Print) daug			rand C)ak		r or Rural Route Num e, Hagersto		yland	21740
	permit. Peges 1 and 2 should Department of Health and Men Important: If item 27 is marke any injury or other treumatic DDGE.		20a. Method of Disposition 1 Burial 2 Cremation 3 Rei 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee		<u>a</u> a	emetery, crer ar Law	natory or oth n Mem.	ner place Pa	rk 3		Hagerst	own,	Maryland
Ba	Depa Impo eny in		Find L. Visit 23a. Part 1. Enter the disease, or complici	ations that cause	ed the death							Mary	1and 21740 Approximate Interval Between
3760,	Coate be executed // Medical Examine sthe pural-transit	edical Examiner	shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infitiated events resulting in death) Last d.	Due to (or a	108	uence of): uence of): uence of): uence of):	Hei Min	or De	per an	antinge adent d pos	Ga ki	les :	25 years 24 years
P.O. Box 68	death certif	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 montbs? 1 ☐ Yes 2 LENo 9 ☐ Unknown	c. If yes, outcom 1 Live birth 4 Pregnant 9 Unknown	2 🗌 Fetal	Ideath 3	Ectopic preg Other (spec			× ,↓		ate of delive	ery Day Year
Records, P.	requires been sign should be	by	Part II. Other significant conditions cont	ributing to death	but not resi	ulting in the u	nderlying cau	use give	in in Part I.	7.m -	Yes 2☐Mo	3 Prob	he cause of death? pably 4 Unknown
	The larate has	Completed	25. Was case referred to medical	TVA C					26 Place	aut per 1 Yes		prior to condeath?	mpletion of cause of
Division of Vital	ding Phys	ilon: To Be	examiner? 1 Yes 2 No Ho 27. Manner of Death 1 Manural 5 Pending	ospital: 1 ☐ Inpa 28a. Date of In (Month, £		ER/Outpatier 28b. Time o Injury		c. Injury Work	E 4 NU	rsing Home 5 🗆 Res 28d. Describe	sidence 6 Do		v)
Division	or Attendatifier deat	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of I building,	njury - At ho etc. <i>(Specif</i>)		reet, factory,		-	28f. Location	(Street and Nuπ lown, State)	ber or Rura	al Route Number,
	the Hospitel on 24 hours a the Funerel C	edical	29a. Certifier 1		of examina								
)	To the compile	W	29b. Signature and title of certifier 30. Name and address of person who con	npleted cause o	M I death (Item	/M/) n 23a) (Type,			number	3/.	29d. Date sign		,0ay, Year) 2024, 7 MD 21742
C	St Regist	ate rar	SHAHAB Z SI AH 31. Date filed (Month, Day, Year) MAR 08 200	7641	strar's Signa	14/4	Cartho	Li	470	TS OVE	16 1L	HAC	711021742

			For	partment of Health and Mertificate of Death		ne 2004 08961	
	Physici /Medic		Decedent's Name (First, Middle, Last) PAULINE RUTH MILLER		2. Date of Death	Day Year 3. Time of Death W	
	Examin		4a. Facility Name (If not institution, give street and number) WASHINGTON COUNTY HOSPITAL	4b. City, Town, or Location of Death HAGERSTOW	J	4c. County of Death WASHINGTON	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 217–32–6922 1		8. Date of Birth (Month, Day, Ye)		
ryland 21215-	should be filed within 72 hours atter deeth with the Maryland Adenial Hygiene. marked other than "natural", or Itame 23a or 28e-f ehow implice event, the Musical Energian matter collined at	To Be Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or MARYLAND WASHINGTON 10e. Street and Number 16505 VIRGINIA AVENUE 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 8 17. Father's Name (First, Middle, Last) CHARLES EDWARD DIEBERT 19a. Informant's Name/Relationship (Type, Print) 10c. City, Town or 10c. City, Town or 11c. City, Town o	WILLIAMSPORT 10f. Zip Code 21795 3. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 Yes 2 No Specify: cedent's Usual Occupation we kind of work done during most of work DO NOT use retired) HOMEMAKER 18. Mother's Name	ecify Yes or No-Rican, etc.) 16b 16c MABLE BII Tal Route Number, Ci	IETLER City or Town, State, Zip Code)	
Baltimore,	permit. Peges 1 and 2 Department of Health ar Important: If Item 27 is any injury or other trau <u>20058.</u>		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 1 ☐ Donation 5 ☐ Other (Specify)	rematory or other place)	9, 04 WI 7606 OI	LLIAMSPORT, MARYLAND LD NATIONAL PIKE DRO, MARYLAND 21713	
8760,	Physician physicien and physicien and physicien and physicien and physicien are the physicien are the physicien are the physicien are the physicien and physicien are the phys	dicai Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not expected the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	Les one was a contract of the	OULCUL	Approximate Interval Between Onset and Death	
P.O. Box 6	es that the death certifi igned by the attending be detached for use as	Physician/Me		3 □Ectopic pregnancy 5 □ Other (specify) e underlying cause given in Part I.	23e. Did tobac	23d. Date of delivery Month Day Year co use contribute to the cause of death?	
Records,	The law ate has b page 2 s	Completed by	Using feet water verous	Hert's	24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death? No 1 Yes 2 No	
Division of Vital	ysician: s certific director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) (Month, Day Year)	ient 3 DOA Other: 4 Nursing Ho	th (Check only one) ome 5 Residence 28d. Describe how in	e 6 Other (Specify) injury occurred	
Divisi	To the Hospital or Attending Ph within 24 hours effer death. To the Funeral Director: After thi completely filled in by the funeral	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stree City or Town, S	t and Number or Rural Route Number, Itate)	
	To the Hospital or A within 24 hours effer To the Funeral Direct completely filled in by	edical (29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	eath occurred at the time, date and place, investigation, in my opinion, death occur	and due to the caus red at the time, date	e(s) and manner as stated. and place, and due to the cause(s)	
)	To the Within Comp	W	29b. Signature and title of confidence	29c. License number DEG FOU	29d.	Date signed (Month, Day, Year)	
	St. Regist	ate rar	30. Name and accessor person who completed cause of death (Item 23a) (Type 23a). Date filed (Month, Day, Year) 32. Registrar's Signature	HON Die !	tagest	aum)21742	

State of Maryland / Department of Health and Mental Hygiene 2004 08962 Certificate of Death Reg. No. 1 Decedent's Name (First, Middle, Last) 2. Date of Death 26 2004 Month Physician EBKUARV MAMIE VIRGINIA NUTTER
4a. Facility Name (If not institution, give street and number) /Medical 4b. Cty, Town, or Location of Death 4c. County of Death Examiner ANNE MANDA Pomense7 RINCESS YANDKIN If Under 24 Hrs. If Under 1 Year 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 □ M 3 F 92 Director 11/2/11 Md 219-07-7796 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "netural", or items 23e or 28e-f showeny Injury or other traumatic event, the Medical Examiner must be notified at 1□Yes 2□No Directo Md Wicomico Nanticoke 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code Wicomico 14. Race - American Indian, Black, White, etc. Funeral P.O Box 154 21840 12. Was Decedent Ever in U,S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Baltimore, Maryland 21215-0020 Specify: Completed by Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 7 1 Own Home House Wife 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ٩ ELT. NUTTER ETHEL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2809 5 Allen Cutoff Rd, Eden, Md 21822

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date 20c. Location - City or Town, State Renola Bounds, Daughter 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Jesterville Cemetery 3/6 Jesterville, Md
22. Name and Address of Facility 21. Signatore of Funeral Service Licensee Moo-417 Messick Funeral Home, P.O. Box 61 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical HENGI FAILUPE Examiner Due to (or as a consequence of): Examine ASCVID or Attending Physicien: The law requires that the death certificete be executed attending physician and for use as the buriel-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or as a consequence of): After this certificate has been signed by the a funeral director, page 2 should be detached to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the ceuse of deeth? 1 Yes 2 No 3 Probably 4 Unknown 2 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 25 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 27. Manufer of Death 1 Naturel 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation after death.

Director: Aff
d in by the fu 1 Yes 2 No 2 Accident 6 Could not be determined To the Hospital or Atterwithin 24 hours after des To the Funeral Director completely filled in by the 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) Medical 29a, Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ww 047094 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SousBury NATESAN 1415 8. DIVISION 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 0 1 2004 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year 0550 M Marion Francis Newlin, Jr. marc 2004 4c. County of Deeth 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Washington Washington County Hospital Hagerstown If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days 1 🕅 M 2 🗆 F 79 09/23/1924 217-12-1216 MD Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 Yes 2 □ No Hagerstown MD Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21740 **USA** 634 Young Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 GYes 2 □ No If Yes, Give 1943–46 Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No Specify: Specify: White 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Plumbing Pipe & Steam Fitting 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Anna (unknown) Sherman Marion Francis Newlin, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 22139 Jugtown Road, Hagerstown, MD 21742 Sharon R. Durboraw, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 03/06/2004 Rest Haven Cemetery Hagerstown, MD *4 □Donation 5 □Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Gerald N. Minnich Funeral Home 305 N. Potomac Street, Hagerstown, MD 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Few wk eral 1a S = uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): on Chron IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 1 Live birth 2 Fetal death Month Day Year in the past 12 months? 4□Pregnant at time of death 5 Other (specify) □Yes 2□No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an 1 🗌 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Hospital: 1 ☐ Yes 2 📉 No 1 patient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatrent 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 🗀 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 — Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 — Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signatur, and title of rtifier ash 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1122 OPALCT, HAGERSTOWN MI) 32. Registrar's Signature

State Registrar

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

Examiner

by Physician/Medical

Completed

Medical Certification: To

Funeral

Director

item 27 is marked other than "natural", or itema 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at

Hygiene.

12 should be filed with and Mental Hygier 7 is marked other th

permit. Pages 1 and 2 Department of Health a Important: If item 27 Is eny injury or other tra

Physician

/Medical Examiner

the attending physician and the for use as the burial-transit

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To the Hospital or Attendii within 24 hours after death. To the Funerel Director: A completely filled in by the fu

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Box 68760,

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Division of Vital Records,

Pages 1 ament of He

72 hours after

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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	4a. Fecility Name (If not institution, give s Waldorf Health				Town, or 11do1	r Location (of Death			County o		
	5. Social Security Number 6. Sex	7. A	ge (In yrs. last birth	day) If Under	1 Year	If Under		8. Date of Bir	th		9. Birthol	lace (State or Foreig
	379 14 0210	M 2 XF 8	8 Y	rs. Months	Days	Hours	Min.	Sept.1	2,19	15	PA	try)
	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location							10	0d. Inside City Limits
ctor	Maryland St. Mary'	s	(Californ	iia							1 ☐ Yes 2 🔀 No
Funeral Director	10e. Street and Number 23160 Whistlewood	d Lano		10f. Zip	Code 2061	10			10g. Cit	izen of WI	hat Coun	try?
era		12. Was Deceden		13. Was Dece	lent of H	ispanic Ori	gin? (Spe	cify Yes or No		14. Race		
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Com	8th			Key Pur	ch (*		_				ernment
Be	17. Father's Name (First, Middle, Last) Antonio	Ce1	ia					(First, Middle Paro)	
ဥ	19a. Informant's Name/Relationship (Ty			Mailing Address	(Street						tate, Zip	Code)
	Daniel A. Fitzpat	rick, Sr	• 1	23160 W	hist							
	20a. Method of Disposition 17 Burial 2 Cremation 3 R	emoval from State	cemetery	Disposition (Nar , crematory or o	ther plac	13	17-3	74 ¹¹ ,		ocation - C		
1	 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 	98	Marylar	d Veter	ans	Ceme	tery	2 004 Funer	Che	1tenh	nam,	Maryland
	Mary E. Helamon	1 1375	+					Ferry				
	23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that cause ne cause on each	line.	t enter the mod	e of dyin	g, such as	cardiac o	r respiratory a	rrest,			Approximate Interval Between
	Immediate Cause (Final disease or condition resulting in death)	ATHE	SAUS C	ALE	Rot	TC	CAR	DioV	AS	cal	An	Onset and Death
		Due to (or a	s a consequence of):				DISE	476			(1/3
ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	s a consequence of):							-	
Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or a	s a consequence of	1.							-	
		0 U O (O I a	s a consequence of	<i>)-</i>								
Medical												
Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		2 Fetal death	3 □Ectopic pr					1	23d. Date Mont		ry Day Year
YSic	1 ☐ Yes 2 🏹 No 9 ☐ Unknown	4∐Pregnant a 9☐ Unknown	at time of death	5 ☐ Other (sp	ecrty)							
Dy Pu	Part II. Other significant conditions cor	tributing to death	but not resulting in	the underlying c	ause give	en in Part I	2/5	23e. Did t	obacco u	ıse contnb	ute to the	e cause of death?
מכן נפ	PERIPHERA	LVA	13 Cal	1310	710	1684	76	1 🗆 '	Yes 2	□ No 3	☐ Proba	ably 4 Minknown
Completed								24a. Was autoj	osy	pri	or to com	osy findings available apletion of cause of
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Du: T	27. Manner of Death	28a. Date of Inj (Month, D	urv 28b. Ti		8c. Injury Work			28d. Describe				,
Certification:	2 Accident investigation 3 Suicide 6 Could not be	One Disco of its	ium. At hama fac	M		Yes 2 🗌		196 i sestion /	Ctt	al 84		Davida Mossiba
ertif	4 Homicide determined	building, e	njury - At home, fare etc. (Specify)	n, street, ractory	, onice		4	City or To			or Hurai	Route Number,
	29a. Certifier 1 Certifying Physic (Check only 2 Medical Exemi	sician: To the bes	t of my knowledge,	death occurred	at the tim	ne, date an	d place, a	and due to the	cause(s)	and manr	ner as sta	ated.
Medical	one)	and manner s	stated.				Occurre					
	29b. Signature and title of certifier					number	3/					Day, Year) 4 2000
-	30. Name and address of person who co	impleted cause of	øleath (Item 23a) (∏	ype, Print)	0	/ /	16		- 1/3			4 2006 MD 2060
	ASHVINKUM	ARJE	ATTELM	0 102	PA	ULN	10/10	N CT	- W	4(D)	urf	MD

		1- State of Maryla		artment of H			iene 19. No. 200	4 0896	
Physici /Medic		1. Decedent's Neme (First, Middle, Last) Lester Clarence Perry				2. Date of Death Month March	Dey Yeer 7 2004	3. Time of Death 5:15 P	
Examir Funeral	ner	4a. Facility Name (If not institution, give street and number) AVa1on Manor 5. Social Security Number 6. Sex 7. Age (In yrs	. last birthday)	4b. City, Town, or Hagersto		8. Date of Birth	4c. County of De Washingt	on	
Director		228-10-2637	Yrs.	Months Days	Hours Min.	03/24/1	919	irthplece (State or Foreig Country) VA	
th the Maryla or 28a-f ehov e notified at	Director		agersto			10	g. Citizen of What C	10d. Inside City Limi 1 Yes 2 N	
72 hours after death with the Maryland naturel', or Itams 23a or 28a-f ehow disal Examinat must be moillied at	by Funeral D	14014 Marsh Pike 11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced 12. Was Decedent Ever in the Armed Forces? 1 ② Yes 2 □ No If Yes, Give Year or Dates:	1	21742 Was Decedent of His If Yes, specify Cubar	spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No- p Rican, etc.)	USA 14. Race - Arr Black, Wh Specify:		
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o a a b o	To Be C	17. Father's Name (First, Middle, Last) Ashby Perry			Mary I	e (First, Middle, M			
permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 is marks eny injury or other traumatic once.			9 Pub Place of Dispo cemetery, creat Charles	olic Squar Sition (Name of matory or other place Borromeo Cer Name and Address OS N. Pot	e, Hager UNK n. UNK	stown, M Date 2 De	0 21740 oc.Location-City o estreham, Minnich Fi	r Town, State LA uneral Home	
death certificate be executed We attending physician and eattending physician and to use as the burial-transit	ilcal Examiner	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consect of the condition of the consect	quence of): quence of): MCUUU	źs				Interval Between Onset and Death 1 ° 2 Why 1 week, 1 Why	
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141	4	29b. Signature and title of certifier ### Comparison of C	1 23a) (Tvna F	29c. License i	6561	29d	Date signed (Mont	h, Day, Year)	
Sta Registr	te ar	Ghazala Qadir, MD, 1190 Mt. Ac	tna Rd		own, MD	21740			

			1_ For	State of Marylar	nd / Depa	artment of H	ealth an	d Mental Hygi	ene 2 N	04 08966
			Registrar		Cel	tificate of L	Jeath	2. Date of Deat	9.110.	
	Physici	an	Decedent's Name (First, Middle, Last)					Month	Day	Year 3. Time of Death
	/Media	al	Hilda Mae P 4a. Facility Name (If not institution, give s			4b. City, Town, or	Location of C	Hoomary	26 Z	cout 301 A M
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	Funeral Director			м ЖXF 80		Months Days	Hours	Hrs. 8. Date of Birth (Month, Day, NOV . 2, 19	^{Year)} 23	Birthplace (State or Foreign Country) Mary land
			Usual Residence of Decedent							7.2
	nylan how		10a. State 10b. County		ity, Town or Lo	cation				10d. Inside City Limits
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	है <u>।</u>	Dire	10e. Street and Number			10f. Zip Code		10	g. Citizen of W	Vhat Country?
	ath w	rai	111 Grove Avenue				1795		1	USA
	er de	une	.,,,,,,	Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin n, Mexican, P	? (Specify Yes or No- uerto Rican, etc.)		e - American Indian, k, White, etc.
36	s afte	γF	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 💢 No If Yes, Give Year or Dates:		1 ☐ Yes 2 🔀 No	Specify:		Specify	
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<u>a</u>	lid be lental rked c	To B	Harry Edgar You	nker			Flor	ence Emil	y Myer	's
Maryland	should and Men marke umatic	-	19a. Informant's Name/Relationship (Ty)		19b. Mailir	ng Address (Street a		r Rural Route Number,		
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatilb and Mental Hygiene. Important: If item 27 is marked other than "natural; or itema 23a or 28a-f show amortant: If item 27 is marked other than "natural; or itema 23a or 28a-f show any righty or other traumatic event. It a Medical Examinat must be notified at ance.		Gary L. Palmer, Sr	Son	60 Ca	ssie Driv	e Fall	ing Waters	.West V	irginia 25419
Baltimore,	of He item item		20a. Method of Disposition		Place of Dispo	sition (Name of natory or other place				City or Town, State
Ē	Page nent c int: if iry or		tXXBurial 2 ☐ Cremation 3 ☐ R *4 ☐ Bonation 5 ☐ Other (Specify)	amovai from State	•			.3.2004 W	illiams	port,Maryland
alti	permit. Page Department of Important: if any injury or once.		2 . Signature of Funeral Service License	90	022	Name and Addres	s of Facility	D. A		por rynar y rano
m	Depa Impo		V DIMIY (IYV		42	5 S. Conc	neral H ocochea	ome, P.A. aue St.Wil	liamspo	r+.MD 21795
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Division of Vital	or Al	Certification:	4 Homicide determined	28e. Place of Injury - At I building, etc. (Spec	ify)	eet, ractory, onice		City or Town	State)	er or Rural Route Number,
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•	4		30 Name and address of porson who co	moleted cause of death (to	m 23a) (Type					
5	Κ,		30. Name and address of person who co Dr Iqbal 12 31. Date filed (Month, Day, Year) MAR 032	821 Oak h	III A.	enve No	agers	town M.	aryla	nd
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)			1- State of Maryland / Dep Registrar Ce	artment of Health and M rtificate of Death	lental Hygien	°2004 08967
	Physici /Medi		Decedent's Name (First, Middle, Last) JACK ALLEN REEVES		2. Date of Death Month D FEBRUARY 1	ay Year 3. Time of Death 6:30P.
	Examir Funeral	ner	4a. Facility Name (If not institution, give street and number) WESTBOUND RT.40 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	4b. City, Town, or Location of Death PERRYVILLE If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year	c. County of Death CECIL 9 Birthplace (State or Foreign Country)
	Director Mouse).	Usual Residence of Decedent 10a. State		JULY 14, 19	40 MARYLAND 10d. Inside City Limits
	72 hours after death with the Maryland natural', or Items 23a or 28a-1 show dical Examinet must be notitled at	rai Director	MARYLAND CECIL ELKTON 10e. Street and Number 366 SKYVIEW ROAD	10f. Zip Code 21921	UI	1 □ Yes 2⊠No itizen of What Country? NITED STATES
9000	72 hours after dea "natural", or Items ideal Examiner	ed by Funerai	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto I		14. Race - American Indian, Black, White, etc. Specify: WHITE
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faryland	2 should be filed within and Mental Hygiene. Is marked other than sumatic event, the M	To Be	JOHN L. REEVES 19a. Informant's Name/Relationship (Type, Print) 19b. Maile	IDA MAY	ABSHIRE Il Route Number, City	or Town, State, Zip Code)
Baltimore, N	Pages 1 and nent of Health ant: If item 27 ury or other tr		20a. Method of Disposition 20b. Place of Disp	V. COURT STREET, #1 position (Name of majors of other place) RTS & CO. MARCH 2004	Pate 20c. L H 2, WES	ND, CA 95695
Balt	permit. Pages Department of Important: If any injury or any injury or		23a. Part 1. Enter the disease, or complications that caused the death. Do not en	2. Name and Address of Facility. CKS HOME FOR FUNEF 0.3 W. STOCKTON STRE	RALS, P.A. EET, ELKTOI	N, MARYLAND 21921
KP	Physician /Medical Examiner be priced and priced but a like a lik	Examiner	shock, or heart failure. List only one cause on each me. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	Injunes		Interval Between Onset and Death
, P.O. Box 68760,	The law requires that the death certificate be exate has been signed by the attending physician page 2 should be detached for use as the buria	by Physician/Medical		□Ectopic pregnancy □ Other (specify) nderlying cause given in Part I.	23e. Did tobacco	23d. Date of delivery Month Day Year use contribute to the cause of death?
il Records,		Completed b			1 Yes 2 24a. Was an autopsy performed? 1 Yes 2 No	No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1/2 Yes 2 No
Division of Vital	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification: To Be	25. Was case referred to medical examiner? 12. Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined 1 Noticide Homicide 28a. Date of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 28b. Time of Injury 38b. Time of Inju	f 28c. Injury at Work? M 1 □ Yes 2/2(No	ne 5 Residence 28d. Describe how inju	Struck by anto
	the Hospital nin 24 hours the Funeral npletely filled	Medical C	29a. Certifier (Check only 2 XMedical Examiner: On the basis of examination and/or in and manner stated.	vestigation, in my opinion, death occurre	ed at the time, date an	d place, and due to the cause(s)
	T V V	2	29b. Signafure and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type,	29c. License number O.C.M.E.		ate signed (Month, Day, Year) RUARY 19,2004
į	Sta Ragist		31. Date filed (Month, Day, Year) MAR 0 4 2004 MAR 0 4 2004	111 Penn Street, B	Baltimore,	Maryland 21201

DHMH 17 Rev 1/2001

ORIGINAL

ern		epartment of Health and Mental I Certificate of Death	Hygiene Reg. No. 2004 08958
Physicia	1. Decedent's Name (First, Middle, Last) Stoven Inverses Stovent	2. Date of Month	Death 3. Time of Death
/Medica Examine	The state of the s	4b. City, Town, or Location of Death North East	4c. County of Death Cecil
Funeral Director	215 27 4601 12 M 2 F 28 Yrs Usual Residence of Decedent	Months Days Hours Min. (Month,	Birth Day, Year) 1 15,1975 9. Birthplace (State or Foreign Country) Maryland
death with the Maryland me 23a or 28a-1 show rmust be notified at	Maryland Cecil North Ea		10d. tnside City Limits 1 ★ Yes 2 No 10g. Citizen of What Country?
A I Z I 3-UUSO ed within 72 hours after ygiene. ier than "natural", or ita t, tre Medical Eramina	423 East Cecil Avenue 11. Marital Status 1	21901 13. Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No Specify: acedent's Usual Occupation live kind of work done during most of working e. DO NOT use refired) er/Operator S&E Enterpris 18. Mother's Name (First, Mid	Specify: White 16b. Kind of Business/Industry Ses Concrete Finishing
arylar 2 should be and Menta and Menta ie marked aumatic ev		Mary E. Carte ailing Address (Street and Number or Rural Route Nu West Over Place, North Eas	er mber, City or Town, State, Zip Code)
Dallimore, M permit. Pages 1 and 2 Department of Health important: if itam 27 any injury or other tre	20a Method of Disposition 20b, Place of Di	sposition (Name of crematory or other place) ast Methodist March 6,200 22. Name and Address of Facility Crouch Ft	20c. Location - City or Town, State North East, Maryland
certificate be executed with the purial-transit and busician and busician and busician and busician-transit and busician-transit and busician-transit and busicians are as the purial-transit and busicians ar	23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate Cause (Final aldisease or condition resulting in death) Sequentially list conditions. If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	enter the mode of dying, such as cardiac or respirator	y arrest, Approximate Interval Between Onset and Death
death certific	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death	3 □Ectopic pregnancy 5 □ Other (specify)	23d. Date of delivery Month Day Year
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this all dir	examiner?	a of 28c. Injury at Work? CL P M 1	esidence 6 Mother (Specify) at Scene se how injury occurred LO ANULY 105+ control, road, WH HALL In (Street and Number or Plural Boute, Number, Town, State) 900 BIK Rock Toad Pd. East, MD 21901 Cecil. Co.
he Hospita in 24 hours he Funeral pletely fille	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, de control on the basis of examination and/or and manner stated.	eath occurred at the time, date and place, and due to ti	he cause(s) and manner as stated
To t with To t	29b. Signature and the Organitation	29c. Licensa number O.C.M.E.	29d. Date signed (Month, Day, Year) March 03, 2004
6	30. Name and address of person who completed cause of death (Item 23a) (Type 5 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -	ne, Print) 111 Penn Street, Baltimo	ore, Maryland 21201
State Registra	31. Date filed (Month, Day, Year) 32. Registrar's Signature	Engles	

		•	For Stata Registrar		Sta	ite of M	larylan	-	artmen rtificate				lental Hyg	iene g. No. 2	2004	08969
			1. Decedent's Name (First, M	iddle, Last,)								2. Date of Deat Month	h Day	Year	3. Time of Death
Ш	Physici: /Medic		ELLA	JAN	E		STE	PHENS					FEBRUAR		,2004	2:00 p M
	Examin		4a. Facility Name (If not instit	_)				Location	of Death		4c. C	ounty of Deat	th
			ATRIA ASSIST	ED LI	VIN	G				ISBU				WI	COMICO	
	Funeral		5. Social Security Number	6. Se:	x] M 2	E8 C		ast birthday)	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day,	Year)	9. Birt	thplace (State or Foreign ountry)
	Director		332-01-2436			ω ·	91	Yrs.					June 24	,191:	2 I1	linois
	D		Usual Residence of Deceden 10a, State 10b, Cou				10c. City	, Town or Lo	cation							10d. Inside City Limits
	sho	5					-									1 √Yes 2 No
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	with the same of t	Funeral Director		_												
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	Hen de	Ĕ	1 Never Married 2	Married	Am	ned Forces	?	. 10.	If Yes, spec	ofy Cuba	n, Mexicar	n, Puerto	Rican, etc.)		Black, Whit	
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212	r tha	E	12	2)	-		3,,	Home	maker					Dome	estic	
	othe ent,	BeC	17. Father's Name (First, Mid	dle, Last)							18. Mothe	er's Nam	e (First, Middle, I	Aaiden Su	umame)	
<u>a</u>	should be filed within ind Mental Hygiene. s marked other than "umatic event, the Max	To E	Harland Erw	ood P	urg	ett					Ma	ary S	S. Body			
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene if the frems 23a or 28a-f show item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, I're Medical Examinat must be notified at	Γ,	19a. Informant's Name/Relat	ionship (Ty	γρe, Pri	int)		19b. Mailin	ng Address	(Street a	and Numbe	er or Run	al Route Number	City or T	Town, State, 2	Zip Code)
Σ	and 2 ealth a n 27 ls		Deborah A. C	ole/d	aug	hter					Dr.,	Sal:	isbury,	MD 2.	1801	
ē	item		20a. Method of Disposition				1 00	lace of Dispo	sition (Nan	ne of ther place				20c. Loca	tion - City or	Town, State
Ë	Pages nent of ent: If it		1 ☐ Burial 2 ☑ Cremat 1 ☐ Donation 5 ☐ Other			ai from State	' Sal	isbury	/ Cre	nato	cy	2/27	/04	Sali	sbury,	MD
Baltimore	permit. Pages 1 and 2 s Department of Health ar Importent: If item 27 Is any injury or other trau		21. Signature of Funeral Sen	rice Licens	98	1		Ĥ	of low	d Addres	s of Facili	al Ho	ome Prof	essi	onal A	ssociation
	20244		23a. P. rt1. Enter the disease	or compl	lications	s that cause	the death						Salisbu or respiratory arm		MD 518	Approximate
	Physician		Immediate Cause (Final disease or condition	List only o	ne caus	se on e ch	line.	20 1.01 0			9,	_	'GPD		j	Interval Between Onset and Death
	/Medical Examiner		resulting in death)		[Due to (or a	s a consequ	uence of):								
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87	cate b	dical			d											
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Box	atten atten for us	ian	23b. Was decedent pregnan in the past 12 months?		1	Live birth Pregnant a	2 Fetal	death 3	Ectopic produced Other (sp.					200	Month	Day Year
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Δ.	The law requires that the ste has been signed by the bage 2 should be detache	문	Part II. Other significant con	ditions co	ntributii	ng to death	but not resu	alting in the u	nderlying c	ause give	en in Part I		23e. Did tot	acco use	contribute to	the cause of death?
ds,	sign d be	d b											124	s 2 🗆 I	No 3□Pr	obably 4 Unknown
Records,	w require been si should b	Completed											24a. Was a	1:	24b. Were au	itopsy findings available
3eC	: The law cate has t page 2 s	mp											autops	y	prior to death?	completion of cause of
a F	ician: Th certificate rector, pag													No	1 🗆 Yes	2 No
Vital	iding Physician: th. : After this certifica funeral director, I	Be	25. Was case referred to me examiner?	-	Hospita	d:				Othe			h (Check only on		70**** (6	-16.1
5	Physithis raldii	٦.	1 Yes 2 No 27. Manner of Death	1	-	ı ∐ınpat L. Date of İni	ury	ER/Outpatier 28b. Time o		8c. Injury Work		irsing Ho	me 5 Reside			ciry)
u	ding h. After fune	tion	1. Natural 5 ☐ Pe	nding estigation		(Month, D	ay Year)	Injury	М		c? Yes 2. □	No				
isi	Attending r death. ector: Atter by the funer	fica	3 ☐ Suicide 6 ☐ Co	uld not be termined	28e	. Place of Ir	njury - At ho	me, farm, str	eet, factory	, office	22				Number or Ru	ural Route Number,
Division	after Dire	Certification;	4 Homicide	temmed		building, e	itc. (Specify	<i>'</i>)					City or Towr	, State)		
_	Hospital 24 hours a Funerel I												and due to the ca			
	To the Hospital or Attend within 24 hours after death To the Funerel Director: completely filled in by the	edical	(Check only 2 Med one)	ical Exami		n the basis nd manner s		tion and/or in	vestigation,	, in my or	oinion, dea	th occur	red at the time, da	ate and pl	ace, and due	to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of ce	rtifier	7	7			290	. License	number		ŀ		signed (Monti	h, Day, Year)
•	> - 0		1 Kinday	علولا	1	Aug.			7	75C	212			5.26	04	
~			30. Name and address of per	son who c	omplete	ed cause of	death (Item	23a) (Type,	Print)	^						
Je	\mathcal{X}		on.charl	Cusa	ch '	" EM	102 B	~3 Blm	543 S+2	J. S	1010	~~~	MD 5. 60			
	Sta	te	31. Date filed (Month, Day, Y	(ear)	004	32. Regi	trar's Signa		$\overline{}$	bour						
	Regist	ar	FEB	262	UU4	0	eper		14	uun	N					

State of Maryland / Department of Health and Mental Hygiene $2 \oplus 0$ 08970 For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Feb.24 2004 Rosalee Dashiell Stanley 9:30 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Salisbury

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Days | Hours | Min. | (Month, Day, Year) 962 Gateway Wicomico Street 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Yrs. Director 213-22-4826 77 Feb.12 Maryland 1927 Usual Residence of Decedent Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mantal Hygiene.
and: If Hean 23 a or 28e-f show and It if I tems 23a or 28e-f show and I tems 23a or 28e-f show and I tems 23a or 28e-f show and I tems 10 or other traumatic event. In Manical Examination 1 Yes 2 No Directo Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 962 Gateway Street 21801 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo þ Specify 3 Widowed 4 ☐ Divorced Year or Dates: Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Domestic None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 Edith Hudson Roland Dashiell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laura Goslee (Niece) 703 Wadena Ave.Salisbury,Md.21801 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If It any injury or o once. rtment of 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3 - 2 - 04Salisbury, Md. Green Acres permit. 21. Signature of Funeral Service Licenses Stewart Funeral Home Bladys B. West Rd.Salisbury, Md. 21801 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** resulting in death) /Medical Due to (or as a consequence of): **Examiner** chronic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed the attending physician and ned for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical as IF FEMALE esn 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 | Fetal death 3 Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) P.O. signed by the a 1 Yes 2 No 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð 1 Yes 2 □ No 3 ☐ Probably 4 ☐Unknown should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? 1 ☐ Yes 2 2 No page 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? director Be 26. Place of Death Check onl one Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA Other 1 ☐ Yes 2 No ٩ 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 27. Manner of Death
1 Natural
2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending Injury 1 Tyes 2 No death. investigation Director: the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) p 4 Homicide hours after within 24 hours a To the Funeral D the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner_stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D1519 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shore Drive, Salisbury Mid 813-B 31. Date filed Month, Day, Year) Dadros 32. Registrar's Signature State FEB 2 6 2004 oaks

Registrar

			For State	State of Man	yland / D	epartment d	of Health and	Mental Hyg	giene 2	004	0807
	然。除 101		Registrar Decedent's Name (First, Middle, L			Dertificate	or Death	2. Date of Dea	leg. No.		3. Time of Death
	Physic		ALFRET	A	, 5	TOULLE	. 7	Month 2	Day 23	Year O4	2301 M
	/Medi Examir		4a. Fecility Name (If not institution, g	ive street and number)		4b. City, Tov	vn, or Location of Deat		4c. County		7,501
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	Funeral		5. Social Security Number 6.	Sex 7. Age (III	In yrs. last birth	Months D	ear If Under 24 Hrs ays Hours Min.	8. Date of Birth	Year)	9. Birthpl Coun	ace (State or Foreign
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	land ow		10a. State 10b. County	10	0c. City, Town	or Location			-	10	Od. Inside City Limits
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2/5	after dea or Items	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	in U.S.	13. Was Decedent	of Hispanic Origin? (S Cuban, Mexican, Puer	Specify Yes or No-		e - America	
10	ours after death with the Maryla el', or Items 23a or 28a-f shov Examinar must be positiou at	by Fu	1 Never Married 2 Married	1 ☐ Yes 2 No If Yes, Give		1 □ Yes 2 🔀		to Frioditi, Sto.j	Specif	ck, White, e	LACK
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Baltimore,	permit. Pag Department Important: I any injury o		'4 □Donation 5 □Other (Spec	-/ / V	MT OLU	E CHURCH	CEM. 31	1 04	LAURE	1	VE.
Ba	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tra		21. Signature of Funeral Service Lice	S		22. Name and Ad	ddress of Facility	ENNIE	Sm	ITH ~	F/H
			23a. Part1. Enter the chease, or con	nplications that caused the	e death. Do no	t enter the mode of	dving such as cardiag	or resouration arre	DALISAL		Approximate
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m.	death e atte id for	icla	in the past 12 months? 1 □ Yes 2 □ No	1□Live birth 2□ 4□Pregnant at time		3 ☐ Ectopic pregna 5 ☐ Other (specify			Mo		Day Year
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Division of Vital Records, P.O. Box	es the	þ	Part II. Other significant conditions	contributing to death but no	ot resulting in t	he underlying cause	given in Part I.	23e. Did tob	acco use contr	ibute to the	cause of death?
ord	requir been si should	Completed	CVA					1 □ Ye	s 2 No	3 ☐ Frobal	bly 4 ∐Unknown
Sec.	ne law has b ge 2 sl	nple						24a. Was an autops	y c	Vere autops rior to com	sy findings available pletion of cause of
<u>=</u>	sician: The la certificate ha rrector, page 3							perform 1 Yes 2	1ed?	leath? □Yes 2	
Ş	ysician: is certific director,) Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	- =		011	th (Check only one			
ð	Phys ar this aral di	: To	27. Manner of Death	28a. Date of Injury	2 ER/Outp	atient 3 DOA	4 🗆 Nursing H	ome 5 Reside			
io	nding ath. r: Afte e fun	atlor	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Ye	ear) Inji		niury at Work? 1 □ Yes 2 □ No				
vis.	er des	Certification:	3 ☐ Suicide 6 ☐ Could not to determined		- At home, farm	n, street, factory, office	се	28f. Location (Str	eet and Numbe	er or Rural I	Route Number,
ā	ital or rrs afte rat Dir led in	Cer						City or Town	•		
	Hospital 24 hours a Funeral tely filled	ical	Check only 2 medical cas	hysician: To the best of my	amination and/	death occurred at the	e time, date and place, ny opinion, death occur	and due to the ca	use(s) and ma	nner as stat	ted.
	To the Hospital or Attending is within 24 hours after death. To the Funeral Director; Atter completely filled in by the funer.	Medical	29b. Signature and title of dertifier	and manner stated.			ense number				
	F × 7 8	117	l. S	- Da.		230. [1	47UC7	29	od. Date signed	rimonth, Da	Hy, rear)
			30. Name and address of person who	completed cause of death	(ltem 23a) /T-	(Oe Print)	11700		4/2)	T	
120				E.Carrollst.	Salis	our W	21801				
		47.77	31. Date filed (Month, Day, Year)	32. Registrar's 3		4 1	ress				
	Registr	ar	FEB 2 5	2004 Dene	/	w ppo	eks/				

		For State Registrar	State of Mary		rtificat				Reg. No.	2004	
Physicia /Medic Examin	al	Decedent's Name (First, Middle, Last LOLA MA Aa. Facility Name (If not institution, give	RIE SMITH		4b. City,		Location of Dea		Day 21	County of Death	
Funeral Director		5. Social Security Number 6. Se	MMAINA 7. Age (In	yrs. last birthday) Yrs.	If Under Months	1 Year	If Under 24 HA Hours Min	8. Date of Bir	th ly, Year)	9. Birth Cou 33 SNOV	n)CO Inplace (State or Formulatry) WHILL MD
* 23	or	Usual Residence of Decedent 10a. State 10b. County MD. WICOMICO		c. City, Town or Lo				7 7 111.	1 9	JJ JINOV	10d. Inside City Lin
23a or 28a-f	ai Director	10e. Street and Number 521 ALABAMA A		3/L1300	10f. Zip	Code 1801			10g. Citi	izen of What Cou	untry?
nal Hygiene. .d other then "natural", or items 23a or 28a-f ehov event, the Medical Examiner mant be notified at	by Funeral	11. Marital Status 1 Never Married 27 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Deced If Yes, spec		ipanic Origin? (, Mexican, Pue Specify:	Specify Yes or No rto Rican, etc.)	ì	14. Race - Amer Black, White SpecifyAFR(
jiene. r then "natur the Medical	Completed	15. Decedent's Edi (Specify only highest grad Elemegrary/Secondary (0-12)	cation le completed) College (1-4or 5+)	(Give	dent's Usua kind of wor DO NOT us ORER	rk done du	uring most of wo	orking		nd of Business/li	ndustry
and Mental Hygiene. s marked other then umatic event, the M	To Be C		I. HUDSON						Maiden	Sumame)	
of Health au f item 27 is r other trau		19a. Informant's Name/Relationship (T) ARUELLA H. SHOC 20a. Method of Disposition 1 △ Burial 2 ☐ Cremation 3 ☐ I	KLEY -SISTER	R 1005 Ob. Place of Disponentery, crei	N. DE	ELAN	AVE.,	SAL ISBU! Date	Υ. 1		1
Department Important; I eny injury o once.		*4 Donation 5 Other (Specify, 21. Signature of Funeral Service Licens		SPRINGHII	2. Name an	d Address	of Facility JOL	LEY MEMO	RIAL	RON MD. CHAPEL	
ysician Medical Medical miner e priial-transit	cai Examiner	23a. Part1. Enter the disease, or comp shock, a heart failure. List only of the composition of the composition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause. Enter Underlying that initiated events resulting in death) Last	Due to (or as a co	nsequence of):	er the mode	e of dying	, such as cardia	LISBURY, c or respiratory a	rrest,	21001	Approximate Interval Between gnset and Death
the attending phy hed for use as th	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pre				2	23d. Date of deliv Month	ery Day Year
sign d be	by	Part II. Other significant conditions co	ntributing to death but no	ot resulting in the u	nderlying ca	ause giver	n in Part I.		obacco u res 2		the cause of death?
ate has page 2	Completed							24a. Was autop perio 1 - Yes	sy rmed?	24b. Were auto prior to co death? 1 \(\sum \text{Yes} \)	opsy findings availa ompletion of cause 2 No
this aldiu	tion; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Accident investigation	lospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day Yea	2 ER/Outpatier 28b. Time of Injury		A Other 8c. Injury : Work?	4 Nursing l	ath (Check only of dome 5 Residence 128d. Describe 1	dence 6		fy)
within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (S	pecify)		, office		City or Tox	vn, State)		al Route Number,
thin 24 hou the Fune mpletely fii	Medical	29a. Certifier (Check only one) 1 ☐ Certifying Phy 2 ☐ Medical Exami	sician: To the best of my ner: On the basis of exa and manner stated.	mination and/or in	vestigation,	in my opi	nion, death occi	urred at the time,	date and	place, and due t	o the cause(s)
T C C C		30. Namer and address of person who co		(Item 23a) (Type,	Print)	2	2839	9	Zyu. Dale	e signed (Month,	
	te	WILLIAM Nobin 31. Date filed (Month, Day, Year) MAR 0 1 20	32. Registrar's S	100 E (ARK	21/2	51 S	AL1564	ins	mo	21101

Smith cola M

		1	For S - State Registrar	tate of Maryland / D	epartment of Health and Certificate of Death	d Mental Hygier	ne 2004 08973
	Physicis		Decedent's Name (First, Middle, Last)			2. Date of Death Month	3. Time of Death
	Physicia /Medic	ai		FARMER SHORT		2 21	04 2030 M
7	Examin	er	4a. Facility Name (If not institution, give stree		4b. City, Town, or Location of De	path	4c. County of Death WORCESTER
	Funeral		5. Social Security Number 6. Sex	L HOSPITAL 7. Age (In yrs. last birth	BERLIN Inday) If Under 1 Year If Under 24 H	Irs. 8. Date of Birth	9 Birtholace (State or Foreign
	Funeral Director		238-40-5782 ^{1□ M}	² √1 F 79 Y	rs. Months Days Hours M	in. (Month, Day, Yea 1 25 2	WILSON, N.C.
7	2 200		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town	or Location		10d. Inside City Limits
Approp	sho	ō	MD. WORCESTE				1 □ Yes 2X No
4	286	Director	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Country?
1	23a or 21 ke		10213 GERMANTOW	N RD.,	21811		USA
) = = = = = = = = = = = = = = = = = = =	ews (Funeral	11. Marital Status 12.	Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	(Specify Yes or No- lerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	or it	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 □Yes 2X□No If Yes, Give	1 ☐ Yes 🎾 No Specify:		SpecifyAFRO-AMERICAN
5-0036	"natural", or items 23a or 28e-f show edical Exercites I.nust be notified at		15. Decedent's Educati	Year or Dates:	Decedent's Usual Occupation		. Kind of Business/Industry
1215	Madis	Completed	(Specify only highest grade co	mpleted)	(Give kind of work done during most of life. DO NOT use retired)	working	
212	giene. er then	E C	10th		OMESTIC		OUSEKEEPING
aryland 21215-0036	e de la g	Be	17. Father's Name (First, Middle, Last) THOMAS FA	RMER	18. Mother's I	Name <i>(First, Middle, Maid</i> ANNIE?	ien Sumame)
aryla	i and z should f Health and Men itam 27 is marks other treumetic	ဍ	19a. Informant's Name/Relationship (Type,		Mailing Address (Street and Number or		ty or Town State Zin Code)
_	Ith an 17 is r 17 is r 1 reur		ANNIE BRITTINGHAM/D	,	19 FLOWER STREET:		
P.	itam 27 tother tre		20a. Method of Disposition	20b. Place of	Disposition (Name of crematory or other place)		Location - City or Town, State
altimofe,			1 ☐ Burial 2 ☐ Cremation 3 ☐ Rem '4 ☐ Donation 5 ☐ Other (Specify)	nval from State		-27-04 BAY	STREET: BERLIN, MD.
alti	permit. Pag Department Important: I any injury o once.		21. Signature of Funerel Service Licensee	1	22. Name and Address of Facility J	DLLEY MEMORI	AL CHAPEL
8	205 2 3		Joulla D	Jolley	1213 JERSEY RD.,		
			23a. Part1. Enter the disease, or complicate shock, or heart failure. List only one of Immediate Cause (Final	ause on each line.			Interval Between Onset and Death
30	hysician /Medical		disease or condition resulting in death)	Due to (or as a consequence of		1 Jone	1 mouth
	xaminer			bue to for as a consequence of	7		
	, ,	je l	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of	f):		
	and transi	Examin	Cause (Disease or injury that initiated events resulting in death) Last	Due to fee as a service of	Λ.		
8760,	I he law fequires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit		security in accumple to	Due to (or as a consequence of	1).		
687	phys phys s the	Physician/Medical	d				
Box (eath certific attending pl for use as t	N/M	IF FEMALE: 23c.	If yes, outcome of pregnancy	0 T5		23d. Date of delivery
m i	dearr ie atte ad for	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fetel death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 □ Ectopic pregnancy 5 □ Other (specify)		Month Day Year
P.O.	that the de ned by the a detached t	Phys	9 Unknown			02a Did tabasa	so use contribute to the cause of death?
S,	res tha signed I be del	þ	Part II. Other significant conditions contrib	luting to death but not resulting in	the underlying cause given in Part i.		2 No 3 Probably 4 Unknown
Records,	w requir been si should I	Completed				24a. Was an	
Rec	has ge 2 s	ig ii				 autopsy performed 	24b. Were autopsy findings available prior to completion of cause of death?
[a]	inciant: The lay certificate has rector, page 2		25. Was case referred to medical		26. Place of	1 ☐ Yes 2 ☐ Death (Check only one)	No 1 Yes 2 No
of Vital	Physician: this certific ral director,	To Be	examiner? 1 Yes 2 No	pital: 1 Impatient 2□ER/Out	Othor	g Home 5 Residence	6 Other (Specify)
0	ng Pn fter th neral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury 28b. T (Month, Day Year) Ir	ijury Work?	28d. Describe how in	njury occurred
slo	Attanding r death. actor: Afte by the fune	catio	2 Accident investigation		M 1 Yes 2 No	004 Lanting (Compa	A and Mushar or Cival Bouts Mushar
	or Ati after d Diract in by	Certification:	4 Homicide determined	 Place of Injury - At home, far building, etc. (Specify) 	m, street, factory, office	City or Town, Si	t and Number or Rural Route Number, tate)
_	To the Hospital or Attanding Prysician: The within 24 Hours after death. To the Funaral Director: After this certificate he completely filled in by the funeral director, page	S	29a. Certifier 1 Certifying Physici	en: To the best of my knowledge	death occurred at the time, date and pl	ace, and due to the cause	e(s) and manner as stated.
	a Hos 124 h le Fur letely	ledical			for investigation, in my opinion, death of		
	To tha within 2 To the complete	Ž	29b. Signature and title of certifier	20	29c. License number	29d.	Date signed (Month, Day, Year)
			, , col	2 0.0.	H44283		2/23/04
n			30. Name and address of person who comp	eleted cause of death (Item 23a) (Type, Print)	Roal	b. Com Man
W_	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signature	had bill	seil	11- 9-110
	Regist		MAR 0 1 200	4 Denie	~ sporks		

			State of Maryland / Department of Health and Mo 1- State Reprint the State of Maryland / Department of Death Certificate of Death	ental Hygiene	2001 00071
			regional		
	Physici	an	1. Decedent's Name (First, Middle, East)	2. Date of Death Month Da	
	/Medic	al	DALE HEN RM SNOONET 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death	March 40	. County of Deeth
	Examir	ier	DOCTORS Community HOSPITAL LAWHAM	9	Prince Georges
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year)	Birthplace (State or Foreign Country)
	Director		578-02-3757	June 24,19	
	and		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
	death with the Maryland ms 23e or 28e-f show	tor	Maryland Prince George's Fort Washington		1 ☐ Yes 2 ☐XNo
-	h the or 28a a noti	irec	10e. Street and Number 10f. Zip Code	10g. Ci	tizen of What Country?
2	23a c	alD	3013 Alderton Avenue 20744		U.S.A.
2	tems	nuel	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Y. 13. Was Decedent of Hispanic Origin? (Spetral Free Forces) If Yes, specify Cuban, Mexican, Puerto Forces	cify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
	rs afte	by Funeral Director	1 Never Mamed 2 Married 1		Specity: White
1	21215-0036 d within 72 hours atter giene. or then "natural", or lite	ted	15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of work)	16b. K	(ind of Business/Industry
Dal	215 ithin 7	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) College (1-4or 5+) Accounting Clerk		ah.a.n.a
0	led will ygien lygien lygien lygien lygien lyf.	ပ်		(First, Middle, Maider	awphone
10	and I be findal H ed ott	Be	17. 1 20161 3 112116 (17/3), 186216, 1230)		
2	Maryland 212' d 2 should be filed withir in and Mental Hygiene. i7 is marked other than treumetic event, the Ma	2	Arthur D. Spooner, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rura.	Poland I Route Number, City	or Town, State, Zip Code)
000	2 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5		Doris M. Spooner (Mother) 3013 Alderton Avenue F	t. Washing	ton Maryland 20744
0	or Health of Health of Health or titem 27 is no other trees.		20a. Mathod of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) March	11.200 4 20c. L	ocation - City or Town, State
S	altimor nit. Pages nartment of ortant: If it injury or o		4 Donation 5 Other (Specify)	Wa	ldorf, Maryland
	Baltimore, permit. Pages 1 a Department of Hes Important: If item any injury or othe once.			e Funeral I	
	W 405 4 4	10.00	Tours (1) 100357 6633 01d Alexandria		Approximate
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac o shock, or heart failure. List only one cause on each line. Immediate Cause (Final		Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):		11010
	Examiner		Severations by Sepsel		7001
	₽ #	iner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury) Due to (or at a consequence of): AULT OLERY Fall VIE		42hr
	ecute and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):		10.11
	760, te be ex ysician	caiE	d		
	687 ificate g phys		0.		0.0
	Box 68' eath certificat attending phy for use as th	M/M	IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy		23d. Date of delivery Month Day Year
	O. B e death	by Physician/Medi	in the past 12 months? 1 Yes 2 No		Month Day Year
	P.C nat the d by ti	Phy	9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
	Division of Vital Records, P.O. I or Attending Physicien: The law requires that the dafter death. Director: After this certificate has been signed by the tin by the funeral director, page 2 should be detached.		Fall II. Other significant contentions continuing to death but not resouring in the alleen ying successful at the	1 ☐ Yes 2	
	v requ	Completed		24a. Was an	24b. Were autopsy findings available
	Re lav	dmc		autopsy performed?	prior to completion of cause of death? 1 2 Yes 2 □ No
	en: T	a	25. Was case referred to medical 26. Place of Death		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
	nysici	To B		me 5 Residence	
	ing Pl		1 ★Natural 5 Pending (Month, Day Year) Injury Work?	28d. Describe how inju	ury occurred
	isio	icat	3 Suicide 6 Could not be 399 Place of Injury. 4t home farm street factory office	28f. Location (Street a	nd Number or Rural Route Number,
	Div A after Direct In by	Certification;	4 Homicide determined building, etc. (Specify)	City or Town, Stat	
	Division of Vital Records, P.O. Box 68760, To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medicai C	29a. Certifier (Check only one) Certifier (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one)		
	o the o the o mple	Mec		29d. D	ate signed (Month, Day, Year)
	FSFO		MD D55075	3	,-4-04
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	CTTZ	greenbelt, Mp 27
	006		BERNAND Farzin MD 7525 Graen way Center Or We 31. Date filed (Month, Day, Year) 32. Registrar's Signature	31,1,	July C. T.
	Si Regis	tate trar	MAR 1 0 2004		

DHMH 17 Rev 1/2001

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State

Registrar

31. Date filed (Month, Day, Year)

MAR 0 5 2004

32. Registrar's Signature

			For State Registrar		State of M		nd / Depa	artment		th and N	Mental Hy	giene Reg. No.	200	4 08976
	Physici /Medic Examir	cal	1. Decedent's Name (First, William Her 4e. Fecility Name (If not ins We about any	itution, give	oemaker street and number)	_			Town, or Loca		2. Date of De Month	2 dc.	County of De	f gapm
	Funeral Director		Washington 5. Social Security Number 214-28-1187 Usuel Residence of Decede	6. Se		ge (In yrs.	last birthday) 68 Yrs.	If Under Months	erstown 1 Year If Un Days Hon	nder 24 Hrs.	8. Date of Bir (Month, Da Aug. 10	th ly, Year)	9. Bi	inthplece (State or Foreign Country) Insylvania
	Marylan a-f ehow	tor	10a. State 10b. C	ounty Ashino	gton		ty, Town or Lo Funkst							10d. Inside City Limits 1 X Yes 2 ☐ No
	3a or 28	al Direc	10e. Street and Number 49 W. Maple	Stre	et			10f. Zip	Code 1734			-	zen of What C	Country?
980	within 72 hours after death with the Maryland ene. then 'netural', or iteme 23e or 28e-f ehow in Medical Expr. arr med by sputified at	Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 □ 3 □ Widowed 4 □ □		12. Was Decedent Armed Forces? 1 Yes 2 1 If Yes, Give Year or Dates:)		Was Deceded of Yes, special			ecify Yes or No Rican, etc.)		14. Race - Am Black, Wh Specify: Wh	ite, etc.
21215-0036	within 72 ho ene. then *netu	mpletec	15. Dec (Specify only Elementary/Secondary (0 Q		ucation de completed) College (1-4or :	5+)	(Give	dent's Usual kind of work DO NOT use	Occupation k done during e retired)	most of work	ing		nd of Busines	s/Industry Company
Maryland 2	should be filed withind Mental Hygiene. marked other then umatic event, ILE M	To Be Co	17. Father's Name (First, M Samuel Richa	rd Sho					1	/argan	e (First, Middle, et Paul	Maiden ine 1	Sumame) Pike	
	C/ 10 - 45		Brian W. Sho 20a. Method of Disposition 1 □ Burial 2 □ Creme	emaker	:/Son	1	717 Place of Dispo	Fores	t Stree	et Hag	al Route Numberstown Date	Mary 20c. Lo	yland 2	21740 r Town, State
Baltimore,	permit. Peges 1 and Department of Health Important: If item 27 any injury or other tr once.		*4 □ Donation 5 □ Ott	er (Specify)		Ce	22	2. Name and	Address of F	acility Do	uglas A	. Fie	ery Fur	n, Maryland neral Home nryland 21742
68760,	Physician /Medical Examiner pe prijaritansi	Ical Examiner	23a. Part 1. Enter the diseas shock, or heard ailure Immediate Cause (Finat disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlyiate cause (Disease or injury that initiated events resulting in death) Last	(a. SEP: Due to (or as Due to (or as	a consect a consect D 10 C	quence of): DIAL quence of): ENIC	IN	FARCT		or respiratory ai	rrest,		Approximate Interval Between Onset and Death
.O. Box 68	The law requires that the death certificate be executed ten as been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physiclan/Med	IF FEMALE: 23b. Was decedent pregna in the past 12 months' 1 □ Yes 2 □ No 9 □ Unknown	11	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Feta	Ideath 3	Ectopic pre Other (spe				2	3d. Date of de	olivery Day Year
٥.	uires that signed b id be deta	by	Part II. Other significant co	nditions co	ntributing to death b	ut not res	sulting in the u	nderlying ca	use given in P	art I.		obacco us		o the cause of death?
al Records,		Completed									24a. Was autop perfo	rmed?	prior to death?	utopsy findings available completion of cause of s 2 \(\text{No} \)
Division of Vital	To the Hospitel or Attending Physician: The within 24 hours after death. To the Funerel Director: After this certificate completely filled in by the funeral director, pag	atlon: To Be	2 Accident	ending vestigation	Hospital: 1 Inpatie 28a. Date of Inju (Month, Da	rv	ER/Outpatien 28b. Time of tnjury		Other	Nursing Ho	n <i>(Check only o</i> me 5 ☐ Resid 28d. Describe h	lence 6		acify)
Divis	To the Hospitel or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	Certification:	4 Homicide	ould not be etermined	28e. Place of tnj building, et	c. (Specil	(y)				City or Tow	m, State)		ural Route Number,
	To the Hospitel or within 24 hours after To the Funerel Dir completely filled in	Medical	one)	olcal Exami	sician: To the best ner: On the basis of and manner sta	t examina	owledge, death	vestigation, i	n my opinion,	death occurr	ed at the time,	date and	place, and du	e to the cause(s)
>	2 Martinos	2	29b. Signature and title of c	entitier	Lin	9		29c.	License numb	341		29d. Date	signed (Mon	2004
3	OH		30. Name and address of pe	de	ompleted cause of d	leath (Iter	п 23а) (Туре,	Print)	H	g M	d 2	176	+0	1
	Sta Registr		31. Date filed (Month, Day,	10 2	32. Registr	ar's Signa	Ature	1	,					

DHMH 17 Rev 1/2001

			. FUI	partment of Health and Nertificate of Death	Mental Hygi	•
	Physici /Medic Examin	al	1. Decedent's Name (First, Middle, Last) LEON WALTER SMITH 4a. Fecility Name (If not institution, give street and number) WASHINGTON COUNTY HOSPITAL	4b. City, Town, or Location of Death	2. Date of Death Month	Day Year 3. Time of Death D5 3004 1047 Am 4c. County of Death WASHINGTON
4	Funeral Director		5. Social Security Number 6. Sex 1 \square 7. Age (In yrs. last birthda $213-16-1474$ 1 \square M $2\square$ F 95 Yrs.	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, JAN. 9,	(ear) 9. Birthplace (State or Foreign Country) MARYLAND
basical put	28a-f show	Director	10a. State 10b. County 10c. City, Town or MARYLAND WASHINGTON	Location KEEDYSVILLE 10f. Zip Code		10d. Inside City Limits 1 ☐ Yes 💥 No
1215-0036 within 22 hours after death with the Maryland	natural', or tiens 23a or 28a-f show	by Funeral Dir	4647 MT. BRIAR ROAD	21756 3. Was Decedent of Hispanic Origin? (Stiff Yes, specify Cuban, Mexican, Puerto		U.S.A. 14. Race - American Indian, Black, White, etc. Specify: White
d 21215-0036	tal Hygiene. d other then "nature event, its Moderi	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	cedent's Usual Occupation ve kind of work done during most of work DO NOT use retired) DRILL PRESS OPERA	ATOR	5b. Kind of Business/Industry TRUCKING MANUFACTURE
Maryland 2	th and Mental H	To Be	17. Father's Name (First, Middle, Last) CHARLES WILFORD SMITH 19a. Informant's Name/Relationship (Type, Print) 19b. Ma		ne (First, Middle, Mi LEN STIN ral Route Number,	€
Baltimore, M	ment of Heal ent: If Itam 2 ury or other		20a. Method of Disposition X Burial 2 Cremation 3 Removal Irom State 20b. Place of Discemetery, compared to the	MT. BRIAR ROAD, Reposition (Name of rematory or other place) M. @ LOC. GROVE3/OS 22. Name and Address of Facility BAST FUNERAL HOME	3/ 2004 I 7606 OI	LE, MARYLAND 21756 C. Location - City or Town, State ROHRERSVILLE, MARYLAN LD NATIONAL PIKE DRO, MARYLAND 21713
60,		dical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not eshock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	enter the mode of dying, such as cardiac pcandral supercl is heart failure and failure chydralian	or respiratory arres	Approximate Interval Between Onset and Death I day
P.O. Box (y the attending physical	Physician/Medl		B Ectopic pregnancy Differ (specify)		23d. Date of delivery Month Day Year
Vital Records, P.O. Box 687	has been signed by the aige 2 should be detached to	Completed by Pl	Part II. Other significant conditions contributing to death but not resulting in the Hyper hat remains	underlying cause given in Part I.	1 ☐ Yes 24a. Was an autopsy performe	2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
DIVISION OF VITAL	s certifica	Certification; To Be Co	25. Was case referred to medical examiner? 1	ient 3 DOA Other: 4 Nursing Ho of 28c. Injury at Work? M 1 Yes 2 No	th (Check only one) ome 5 Residen 28d. Describe how	
VIU	within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral in the fu	Medical Certif	29a. Certifier (Check only one) Continued	ath occurred at the time, date and place	City or Town,	se(s) and manner as stated.
		Me	29b. Signature and titled certifier	29c. License number	M	d. Date signed (Month, Day, Year) MCh Ok, 2004
54	Sta Registr		30. Name and address of person who completed cause of death (Item 23a) (Typ ZAFTA MINLK MI) 31. Date filed (Month Pan Year) 8 2004 32. Rigistrar's Signature	Print PANS LO BOOM	ISBORD	MD 21713.

State of Maryland / Department of Health and Mental Hygiene 2004 Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) Month Year **Physician** 0254 AM 2004 JUANITA FLORA SAYLOR /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** WASHINGTON COUNTY HOSPITAL HAGERSTOWN WASHINGTON If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Min. Months 1 □ M 2 🛛 F Yrs. Director 577-32-1850 79 SEPT. 1 1924 MARYLAND Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene.
snt: If Item 27 is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, the Medical Examinat must be notified at 1 ☐ Yes 2 No Director MARYLAND WASHINGTON KEEDYSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19022 SHEPHERDSTOWN PIKE 21756 U.S.A. Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? ☐Yes 2∏No 1 ☐ Never Married 2 ☑ Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Year or Dates: Specify. 3 Widowed 4 Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) NURSES AIDE VETERANS HOSPITAL 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ARNOLD JAMES INGRAM LILLIE MAE JAMISON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RODNEY F. SAYLOR/SON 19016 SHEPHERDSTOWN PIKE, KEEDYSVILLE, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or 4 ☐ Donation ☐ Other (Specify) SAMPLES MANOR CEMETERY 3/5/2004 SHARPSBURG, MARYLAND 21. Signature of Funeral Service Consee 22. Name and Address of Facility 7606 Old NationalPike BAST FUNERAL HOME Kelly A. Limmer man Boonsboro, Maryland 21713 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician onewell /Medical Examiner Renal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical Examiner Clastridium difficile enterocolitis physicien and s the burial-transit Preumonia one mont IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 4□Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 25. Was case referred to medical examiner? 1 Yes 2 No Vital or Attending Phyaician: 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Division of 27. Manner of Death
1 Natural
2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Director 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28I. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after d To the Funeral Direct completely filled in by 4 Homicide the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) March 3, 2004 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2AT-AR MALIK MD. 22311 LAPPANS RD BOONSBERO MALIK MD. 31. Date liled (Month, Day, Year) 32. Begistrar's Signature State parte Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2004 March 02, **Physician** Doris Jane Smith 3:20 p /Medical 4c. County of Deeth 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington Williamsport Homewood at Williamsport If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth Day, Year) Jan. 04, 1920 Birthplece (State or Foreign Country)
 PA 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 ☐ F 579-16-8487 84 Yrs Director Usual Residence of Decedent 10c. City, Town or Location
Shepherdstown 10d. Inside City Limits with the Maryland 10h. County 10a. State or 28a-f show event, the Mudical Extrainer trust be notified at WV Jefferson 1 Yes 2 □ No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 25443 United States 2009 Chatfield Drive "natural", or Items 23a Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Ite any injury or other traumatic event, the Medical Exercitiva 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No White Specify: If Yes, Give Year or Dates: 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Resturant Hostess 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Josephine M. Show Harry B. Miller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) P.O. Box 962, Shepherdstown, W 25443 Sharon J. Sechler-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State Mar. 5,2004 Shepherdstown, WV Elmwood Cemetery 4 Donation 5 Other (Specify) 22 Name and Address of Facility

Melvin T. Strider Co.Inc. 21. Signature of Funeral Service Licenset CS FALP HUBINO? 310 South Fairfax Blvd., Ranson, W 25438 Appro de the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Par1. Enter the disease, or shock, or heart failure. List complications that cap Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner END 5176 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760, physician for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but newcesulting in the underlying cause given in Part I. Division of Vital Records, should be 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No М To the Funeral Director: A completely filled in by the fu 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signa MEDI WIR acoun address of person completed cause of death (item 23a) (Type, 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 04 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** March 4, Wesley Allen Tyson 2004 0204 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Cecil. North East 139 Plum Creek Road | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 1930 | Months | Days | Hours | Min. | (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Days Hours 1 XM 2□ F 73 214 26 4609 September 3, Maryland Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Director Maryland Cecil North East 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or Items 23a or 139 Plum Creek Road 21901 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after Hygiene. 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ğ 3 Widowed 4 Divorced "naturel", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Law Enforcement Elementary/Secondary (0-12) College (1-4or 5+) 12 Police Officer Civil Service other 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be filt. Department of Health and Mental Hy Importent: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) Be Roland Tyson Eva G. Walker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Eleanor M. Tyson/Spouse 139 Plum Creek Road, North East, Maryland 20b. Place of Disposition (Name of 20c. Location - City or Town, State North East, 20a. Method of Disposition North East Methodist March 8, 1X Burial 2 ☐ Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Cemetery Maryland 21. Signalur and Furteral Pervice License Crouch Funeral Home 127 South Main Street, North East, Maryland 21901 23a. Part1. Enter the disease, or complications that can ed the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on part line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 3 Probably 4 □Unknown Completed certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an No. 1 Yes 1 Yes To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certifica 25. Was case referred to medical examiner? neral Director: After this certific filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Desidence 6 Other (Specify) 2 No Certification; To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Mann of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Yeer, 28d. Describe how injury occurred 28b. Time of Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier ical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 1001 31. Date filed (Month, Dey, State Registrar 5 2004 DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2001

Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Deta of Death Month **Physician** Yaar JULIUS MAXY TRAPP 24, FEB. 2004 0145 /Medical 4b. City, Town, or Location of Daath 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner 11431 MANKLIN CREEK ROAD, UNIT 2 OCEAN PINES WORCESTER If Undar 1 Yaar If Undar 24 Hrs. 8. Data of Birth (Month, Dey, Yaer) 5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foreign Country) **Funeral** 1⊠M 2□ F Months Days Hours Yrs. JAN 29, 1924 Director 218-14-5099 80 MARYLÁND Usual Rasidanca of Decedent Peges 1 end 2 should be filed within 72 hours efter death with the Marylend 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yas 2 No Director MD WORCESTER OCEAN PINES 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 11431 MANKLIN CREEK ROAD, UNIT 2 21811 USA Funeral 12. Was Decedant Evar in U,S. Armed Forcas? 1 M Yas 2 □ No If Yes, Giva Yaar or Datas: WWII Was Decadant of Hispanic Origin? (Specify Yas or No If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 1 Never Marriad 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yas 2 💆 No Specify: þ Specify: 3 X Widowad 4 □ Divorced WHITE Completed 16a. Dacedant's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa ratired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Collega (1-4or 5+) Elamantary/Secondary (0-12) permit. Pages 1 and 2 should be filed with Depertment of Heelth and Mental Hygian Important: If them 27 is marked other the any Injury or other traumatic event, the DDRB. CONTRACTOR PLUMBING & HEATING 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middla, Maiden Surname) Be JULIUS MAXY TRAPP SR. IRMA LANGELUTTIG 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Routa Numbar, City or Town, Stete, Zip Code) J. MAXY TRAPP III -SON 4 BARN OWL DRIVE, SELBYVILLE, DE 19975 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) CREMATORY OF DELMARVA 2/26/04 DELMAR, DE 21. Signatura of ral Service Licensae 22. Name and Addrass of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE 19975 23a. Part 1. Entar tha disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or haart failura. List only one cause on a der line. Approximata Interval Batween Onsat and Death **Physician** Immediate Causa (Final disaasa or condition resulting in death) /Medical 263 Examiner Dua to (or as a consequence of) Physician/Medical Examiner The lew requires that the death certificate be exacuted ettending physicien end for use es the bunal-trensit Sequentially list conditions, if any, laading to immadiate ceusa. Entar Underlying Causa (Disaasa or injury that initiated avants rasulting in death) Last Dua to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequance of): signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco usa contributa to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performad? Completed hes this certificate he ral director, page 1LIYes 2 Vili 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: **Director:** After this certific I in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Homa 1 ☐ Yes 2 Ho 2 ☐ ER/Outpetient 3 ☐ DOA sidence 6 Othar (Specify) 27. Mannar of Daath 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending invastigation Natural 1 🗌 Yes 2 🗆 No efter death 2 Accidant 3 Suicida 6 Could not be detarmined 28f. Location (Streat and Numbar or Rural Route Number, City or Town, State) To the Hospital or Atte within 24 hours effer de To the Funeral Directo completely filled in by the 28a. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 - Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier 29b. Signature and little 29c. License number 29d. Date signed (Month, Day, Year) cause of death (Item 23e) (Type, Print) ourta Borodula NIMELOS Cus 31. Data filed (Month, Day, Year) FEB 2 5 2004 32. Ragistrar's Signature Registrar

DHMH 16 Rev 6/95

		T = State Registrar				rtificate	e OI L	Jeaui			Reg. No	. 20	U is	JB^{\prime}
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Physici /Medi		MARVIN	OLIN	TIL	GHMAN					EBRUARY	21	2004	ear + 1:10	0 PM
Examir		4a. Facility Name (If not institution, gi	ve street and nu	mber)		4b. City,	Town, or	Location of	of Death		40	. County of	Death	
Jon		WICOMICO NURSINO				SALIS						/ I COM I CO		
Funeral Director		224-18-2891	Sex 1 <mark>x</mark> ∏M 2□F	7. Age (In yrs. 81	last birthday, Yrs.	Months	1 Year Days	If Under Hours	Min.	8. Date of Bi (Month, D Septemb			Birthplace (S Country) Virgi	
and w		Usual Residence of Decedent 10a. State 10b. County		10c. Ci	ty, Town or L	ocation							10d Ins	ide City L
Mary f shc	or	Marriand Winson												Yes 2
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n 72 hours after death with the Marylar "natural", or Iteme 23s or 28s-f show Idical Examilinar must be notified at	Completed	15. Decedent's E (Specify only highest gi			16a. Dece	dent's Usua	l Occupa	ition	t of workin	na			ess/Industry	
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ould Men Marke Marke	ဥ	Harold Marion	_	ın						nn Stu				
12 sh h and 7 is m traum	1	19a. Informant's Name/Relationship Aileen W. Tilght											te, Zip Code)	1005
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DHMH 17 Rev 1/2001

Amended Item 26 per Physician 03/05/2004 Carroll County, wil Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** TAWNEY WALTER FEBRUARY Year 7:20 A M 2004 28 /Medical 4a. Facility Name (If not institution, give street and number) Ab. City, Town, or Location of Down 4c. County of Death Examiner CENTER HOSPITAL NORTHWEST BALTIMORE. 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 6 Sev 8. Date of Birth (Month, Day, Year) October 5 1930 7. Age (In vrs. last birthday **Funeral** Birthplace (State or Foreign Country) Days 1⊊ M 2□ F 73 Director 220-26-7212 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner roust be notified at Howard Director MD 1 ☐ Yes 2 XNo Woodstock 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8934 Wrights Mill Road 21163 by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1X Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify: White Specify: 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w
Department of Health and Mental Hygier
Important: If Item 27 Is marked other it
any injury or other traumatic Machinist 12 Black and Decker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ဂ္ James D. Tawney, Sr Ethel Gertrude Groft 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Kahn/son-in-law 8934 Wrights Mill Road Woodstock, MD 21163 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 3/03/2004 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 ☑ Other (Specific Intombment Evergreen Memorial Gardens Finksburg, MD 22. Name and Address of Facility
Pritts Funeral Home and Chapel, P.A. 21. Signature of Funeral Service Licensee 412 Washington Road Westminster, MD 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final D198198 CHRONIC OBSTRUCTIVE PULMONARY **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of): attending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? FIBRILLATION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown HYPERTENSION. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?: Yes 2 No 1 ☐ Yes 2□ No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 2 1 Yes 2 No Hospital: 1 X Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death
1 X Natural
2 ☐ Accident 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Medical Certification: 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

The law requires that the death certificate be executed P.O. Box 68760 detached Division of Vital Records, page 2 or Attending Physician: filled in by the funeral after death. within 24 hours a To the Funeral I To the Hospital

he

28a-f show

or Items 23a

filed within 72 hours after a Hygiene. Ither than "natural", or Ite

Baltimore, Maryland 21215-0036

completely WIL

> State Registrar

29c. License number 42723.

OLD

29d. Date signed (Month, Day, Year) FEBRUARY 28 2004

30. Name and ddress of person who completed cause of death (Item 23a) (Type, Print) NORTH WES AVVERA HALLI M HARISH 5401 51 AVUERA HALLI

5401

HOSPITAL OURT ROAD

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

32. Registrar's Signature

		1 - For State Registrar	State of Maryland	l / Depa <i>Cer</i>	rtment o	of Health and of Death		giene 200	4 08985
Physic /Med Exam	lical	Decedent's Name (First, Middle, Last) Janet M. Unger 4a. Facility Name (If not institution, give structure) Washington County			1 1	wn, or Location of Deat		Day Year	0410:17 M
Funera Directo		5. Social Security Number 6. Sex	7. Age (In yrs. Ia	st birthday) Yrs.	If Under 12	rear If Under 24 Hrs Days Hours Min.	8. Date of Birtl	h 9. Bi	nthplace (State or Foreign Jountry) gesville WV
in the Maryland or 28a-f ahow	Irector	10a. State 10b. County PA Franklin 10e. Street and Number		, Town or Loo Thom		ode		10g. Citizen of What C	10d. Inside City Limits 1 ☐ Yes 2 🖾 No country?
III. Z I Z I 3-0030 be filed within 72 hours after death with the Maryland tal Hygiene. Id other then "natural", or items 23a or 28a-f show " event, the Medical Exactine mat be putitied at	by Funeral Director	2474 McDowe11 RD 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S Armed Forces? 1 _ Yes _ 2 \overline{Order} No If Yes, Give Year or Dates:		Was Decedent Yes, specify	17252 It of Hispanic Origin? (S Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	USA 14. Race - Am Black, Wh Specify: Wh	ite, etc.
led within 72 ho led within 72 ho lygiene. har than "natur nt, the Medical.	Completed	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12) 8	ation completed) College (1-4or 5+)	(Give life. L	tent's Usual C kind of work o DO NOT use	done during most of wo retired)		16b. Kind of Busines: Clothi Maiden Sumame)	
aryialru 2 should be fill and Mental Hi Is marked oth sumatic even	To Be	Marvin M. Wilson 19a. Informant's Name/Relationship (Type	e, Print)			Dora	G. Byers	S er, City or Town, State,	Zip Code)
paritimore, Interpreted within 72 hours after death with the Marylan permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examines must be publified at	OUCE.	LaJana L. Fahnest 20a. Method of Disposition 1 Burial 2 Cremation 3 Re 4 Onation 5 Other (Specify) 21. Signature of Funeral Service Licensee	moval from State 20b. Place Gre	en Hil	sition (Name natory or othe L1 Ceme . Name and	etery Mar.	11, 200 ove-Bower	20c. Location - City of 04 Waynesborsox Funer	oro, PA 17268 al Home, Inc.
anth certificate be executed attending physicien and for use as the burial-transit	ical Examiner	23a. Part Lenter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	Due to (or as a consequence to	Do not enter					Approximate Interval Between Onset and Death
. 0 00	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ic. If yes, outcome of pregnar 1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown	death 3	Ectopic preg Other (spec			23d. Date of di Month	elivery Day Year
OrdS requires been sign	þ	Part If. Other significant conditions cont END STACE LENA ELECTRICAL ADDA (1)				se given in Part I.	1 🗆 Y		Probably 4 []Unknown
I Ke The la ate has page 2	Be Completed	CHOOITE ALMS 25. Was case referred to medical	ST.	HMIII)				prior to death?	
OT Phy r this	2	1 Yes 2 No Property No. 1 Yes 2 No. 1 Yes 2 No. 1 Yes 2 No. 1 Yes 2 Yes 2 Yes 2 Yes 2 Yes 2 Yes 2 Yes 2 Yes 2 Yes 2 Yes 2 Yes 2 Yes 2 Yes 2 Yes 2 Yes 2 Yes 2 Yes 2 Yes 2 Yes 2 Yes 2 Yes 2 Yes 2 Yes 2 Yes 2 Yes 2 Yes 2 Yes 2 Yes 2 Yes 2 Yes 2 Yes 2 Yes 2 Yes 2 Yes 2 Yes 2 Yes 2 Yes 2 Yes 2	ospital: 1 ☑ Inpatient 2 ☐ 1 28a. Date of Injury (Month, Day Year)	ER/Outpatien 28b. Time of Injury		Other: 4 Nursing Injury at Work? 1 Yes 2 No		dence 6 Other (Sp now injury occurred	ecify)
DIVISION Hospital or Attending 24 hours after death. Funeral Director: After letely filled in by the func-	al Certification:	3 Suicide 6 Could not be determined 29a. Certifier 1 Certifying Physical Country of the Country	28e. Place of Injury - At ho building, etc. (Specify ician: To the best of my known of the best of my known of the best of my known of the best of my known of the best of my known of the best of my known of the best of my known of the best of my known of the best of my known of the best of my known of the best of my known of the best of my known of the best of my known of the best of the	vledge, death	h occurred at	the time, date and place	City or Ton	cause(s) and manner a	as stated.
d	Medical	(Check only 2 Medical Examin one) 29b. Signature and title of certifier	er: On the basis of examinat and manner stated.	ion anworth	29c. 1	icense number		29d. Date signed (Mor	
Regi	State strar	30. Name and address of person who cor	mpleted cause of death (Item 1 2 9 3 1 32. Registrar's Signal	23a) (Type,	Print) Hill	Ave. H	q. md	21742	

			1 - For State Registrar		aryland / Dep <i>Ce</i>	ertificate of Deal	th and Mental H	ygiene 2001 Reg. No.	+ 08981
	Physic		1. Decedent's Name (First, Middle, La Elva	Ruth	Verno	n n	2. Date of D Month	Day Year	3. Time of Death
*	/Medi Examii		4a. Facility Name (If not institution, given		VETTI	4b. City, Town, or Locat	Mar tion of Death	6 2004 4c. County of Dea	4:45 P M
	Funeral Director		Civista Medic 5. Social Security Number 6. 9 579-05-3439 Usual Residence of Decedent		r e (In yrs. last birthday 85 Yrs.	LaPlata // If Under 1 Year If Under 1 Year Hou	nder 24 Hrs. 8. Date of B (Month, E Mar. 4	Charles	thplace (State or Foreign DMONS , MD
	/land		10a. State 10b. County		10c. City, Town or L	ocation		-	10d. Inside City Limits
	B Man	ctor	MD Charle	es :	Waldorf				1 □Yes 2X No
	th with th	Funeral Director	10e. Street and Number 11678 Vernon Rd			10f. Zip Code 20601		10g. Citizen of What Co	ountry?
900	be filed within 72 hours after death with the Maryland hal Hygiene. d other than "natural", or Items 23a or 28a-f show event, the Medical Examinar must be notified at	by	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🂢 Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 11 If Yes, Give Year or Dates:		Was Decedent of Hispanic If Yes, specify Cuban, Mes 1 ☐ Yes 2 No Specify		14. Race - Ame Black, Whit Specify: W	e, etc.
Maryland 21215-0036	within 72 he iene. t han "natu he Medical	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation ide <i>completed)</i> College (1-4or 5	+) (Give	edent's Usual Occupation e kind of work done during a DO NOT use retired) OCK Clerk	most of working	16b. Kind of Business	Industry
and 2	ed at b	Be	17. Father's Name (First, Middle, Last, Harry Olsen, Si		1 30	18. M	other's Name (First, Middle	e, Maiden Sumame)	
ary	97	J.	19a. Informant's Name/Relationship (19b. Mail	ing Address (Street and Nu	Mary Ethel Somber or Rural Route Numb		Zip Code)
	1 and 2 Health a om 27 le		William W. Olsen	- Brother	1134	5 Berry Rd.,		20603	
Baltimore,			20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐	Removal from State	1	matory or other place)	Date	20c. Location - City or	
Ħ	permit. Page Department of Important: If any injury or once.		' 4 ☐ Donation 5 ☐ Other (Specifical Signature of Fone (al, Service Licer			lem. Gardens		4 Waldorf,	MD
Ba	permit. Departn Imports any inju		by Nack A. C	Ils &		2. Name and Address of Fa Huntt Funera P.O. Box 156	l Home . Waldorf. N	4D 20604	
***	Physician /Medical Examiner	Examiner	23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a. Out to (or as:	a consequence of):	0 0	otr hong		Approximate Interval Between Onset and Death
Box 68760,	ie death certificate be executed the attending physicien and hed for use as the burial-transit	Physician/Medical Exa	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	d	2 ☐ Fetal death 3 [□Ectopic pregnancy □ Other (specify)		23d. Date of deli Month	very Day Year
ords, P.O.	w requires that the de been signed by the s should be detached f	þ	Part II. Other significant conditions of		t not resulting in the u	nderlying cause given in Pa	10	tobacco use contribute to Yes 2 2 No 3 Pro	the cause of death?
al Rec	n: The law i ficate has b or, page 2 sh	Completed	OF Was and and a start of						opsy findings available ompletion of cause of
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death. To the Funeral Director After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be detached for use	atlon; To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	Hospital: 1 Inpatier 28a. Date of Injury (Month, Day	28b. Time o	nt 3 DOA Other: 4	10		ify)
Divis	tal or Atters after de al Directo	Certification;	3 Suicide 6 Could not be determined	28e. Place of Inju- building, etc.	ry - At home, farm, str (Specify)	eet, factory, office	28f. Location (City or Tou	Street and Number or Rui wn, State)	al Route Number,
	To the Hospital within 24 hours a To the Funeral I completely filled	edical	29a. Certifier 1 ☐ Certifying Ph (Check only one) 2 ☐ Medical Exam	vsician: To the best or iner: On the basis of and manner stat	axamination and/or in	occurred at the time, date vestigation, in my opinion, o	and place, and due to the death occurred at the time,	cause(s) and manner as date and place, and due	stated. to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier			29c. License numbe	ər	29d. Date signed (Month,	Day, Year)
			B. ha cealest	R.D		D-005694	9	3/7/04	
N	d 6		30. Name d address of person who of Kamakshi Baig, N	ID 6620	Crain U.	rr Cuita 10	2 LaPlata	MD 20646	
18	Sta Registra	ar	31. Date filed (Month, Day, Year) MAR 0 8	2004	we do	books			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Vear **Physician** WYKTT 13=40 HERMAN MAZLU RATMONDA 2 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HarFors EN UPPURCHEDAPEAKEMEDICALCENITOL 3 12 x41 1 If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** 1 X M 2 □ F 217-36-3020 65 1938 Maryland Director Usuat Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a, State 10b. County "natural", or Items 23a or 28a-f show 1 ☐ Yes 2 No Cecil Rising Sun Directo Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21911 623 Rising Sun Road Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: þ White 3 Widowed 4 St Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Country TV Elementary/Secondary (0-12) College (1-4or 5+) Rising Sun, Maryland Owner/Operator Twelve Years and Mental Hygie 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Duld be f Blanche Stidham Charles H. Wyatt ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2.
Department of Health al
Importent: If item 27 is
any injury or other trau 141 Post Road, Aberdeen, Maryland Mark A. Wyatt (son) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 03/05/04 West Chester, Pennsylvania R.A. Ferris & Co., Inc. * 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766 Unonias M. CHUELLON, Sr. Approximate tnterval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final HASLVD **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate rause. First Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner that initiated events resulting in death) Last signed by the attending physician and Due to (or as a consequence of) by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Live birth 2 | Fetal death Year Month Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No be detached P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 Probably 4 SUnknown Duronothy Completed been: 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a Wasan this certificate has 1 Yes 25 No VULCV HEART BIJEAS To the Hospitel or Attending Physician: within 24 hours after death.
To the Funerel Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitat: 1 ☐ Inpatient 2 ☑ EP/Outpatient 3 ☐ DOA Medical Certification: To 1 Yes 2 No 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MARCH 2, 2004 021809 1141 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 45PNABHU 2336 YOUR NO M-0 1, WOW WINN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State S. Carlotte Registrar MAR 0 5 2004

Kaymond

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** LOUISE WHITE 21 6:15 PM NOCK February 2004 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner WICOMICO SALISBURY WICOMICO NURSING HOME If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Months 1 ☐ M 2 🛣 F 102 August 12,1901 Maryland Director 217-44-2259 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County or items 23s or 28s-f show runer rest by notified at 1 X Yes 2 No Maryland Wicomico Salisbury Direct with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21801 813 Smith St. USA death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Maryland 21215-0036 ò 1 ☐ Yes 2X No Specify: white ğ 3 Midowed 4 □ Divorced "natural" or than "nature the Medical E Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Coltege (1-4or 5+) 8 Homemaker Domestic n and Mental Hygier Is marked other ti 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Charles Henry Nock Anna Kenly traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Heeith a H Item 27 Is or other tran Fred White/son 605 Ardmore Terrace, Salisbury, MD 21804 Baltimore, 20b. Place of Disposition (Name of cometery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department o Important: If eny injury or once. Parsons Cemetery 2/26/04 Salisbury, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Holloway Funeral Home Professional Association 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. 501 Snow Hill Rd., Salisbury, MD 21804 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CORONARY Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, in any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off. Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-trar Due to (or as a consequence of): he attending physicien Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown à signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ DEMENTIA 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 Yes PNo this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After Matural 5 Pending s after death. 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours after To the Funeral Dire 29a. Certifies Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29h Sid witte of certifier 1255001 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 614 EASTERNSHORE DRIVE, SALISBURY, MD 21804 MOHAN BHAT, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene

			State of Maryland	Certificate of Death	Reg. No. 200	1. 09090
	Div		Decedent's Name (First, Middle, Last)		2. Date of Death Month Dey Year	3. Time of Death
1	Physici /Medic		Dorothy Viola Williams		March 5, 2004	10:55PM
1	Examin	er	4a Facility Neme (If not institution, give street and number)	4b. City, Town, or I	,	
			Charles County Nursing & Rel 5. Social Security Number 6. Sex 7. Age (In yrs. last)			
	Funeral Director		220 - 28 - 5108 1□ M 2¼F 87 Usual Residence of Decedent	Yrs. Months Days Hours Min.	B. Date of Birth (Month, Dey, Yeer) Dec. 25,1916	irthplace (State or Foreign Country) aryland
	land			wn or Location		10d. Inside City Limits
	Man a-f st	ģ	MD Charles La	Plata		1X Yes 2 □ No
	or 28	Fe	10e. Street and Number	10f. Zip Code	10g. Citizen of What C	Country?
	ath w	Ta	10200 La Plata Road	20646	USA	
Maryland 21215-0020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23s or 28s-f show any Injury or other traumatic event, the Medical Examinet must be notified at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U,S. Armed Forces? 1 □ Yes 2 □ ▼ lo If Yes, Gwe Year or Dates:	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerton 1 ☐ Yes 2 ☐ No Specify:	pecify Yes or No- o Rican, etc.) 14. Race - Arr Black, Wh Specify:	
2-0	72 ho	Completed	15. Decedent's Education 16 (Specify only highest grade completed)	a. Decedent's Usual Occupation (Give kind of work done during most of wor life. DO NOT use retired)	king 16b. Kind of Busines	s/industry
12	hen.	ם	Elementary/Secondary (0-12) College (1-4or 5+)		Count	y Schools
5	Hygien Ther th	ပိ	10 17. Father's Neme (First, Middle, Last)	Cafeteria Worker	ne (First, Middle, Maiden Sumame)	., 551155
an	d be f	To Be	Theodore Herbert		R. Moran	
ary	should be and Mental is marked of umatic eve	F		9b. Mailing Address (Street and Number or Ru		Zip Code)
ž	and 2 salth a n 27 is			303 Arlington Dr.	La Plata, MD. 2	0646
Baltimore,	Pages 1 annount of He Int: If Item		1A Burial 2 Ucremation 3 Li Hemoval from State	of Disposition (Name of lery, cremetory or other place) 03- ity Memorial Garde	-09 04 20c. Location - City of Waldorf,	
alti	Departm Mporta any inju		21. Signature of Funeral Service Licensee M00817	22. Name and Address of Facility Arehart - Echol		
ш	205 2 2		Mauric. Chole	P.O. Box 567	La Plata, MD 2	0646
	\ <u>a</u>		23a. Part1. Enter the disease, or complications that caused the death. D shock, or heart tailure. List only one cause on each line.	not enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death
-	Physician /Medical		Immediate Cause (Final	VASCULAR X	CCIDITAT	4 Moult
	Examiner		rooditing in doutin		CC DON', 2	T 110000
À		Je	Due to (or as	a consequence of):		
	tificata be executed g physician and as the burial-transit	edicai Examiner	Sequentially list conditions, Due to (or as	a consequence of):		
60,	be exercian a	E	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
68760,	phys s the	odic	that initiated events Due to (or as a resulting in death) Last	a consequence of):		
Box (d			
m.	death e atte	icla	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.	23b. Did tobacco use contribut	te to the ceuse of death?
P.O.	v requires that the death cer bean signed by the attendin should be datached for usa	Phys		mIA	1 ☐ Yes 2 ☐ No 3 ☐ 1	Probably '47 Unknown
ś	es the	۵	CAS :-DIAC ALKAITION	•		
ord	ean s hould	eted	DEMENTIA		24a. Was an autopsy 24b. performed?	. Were autopsy findings available prior to completion of cause
Division of Vital Records,	The law requires that the death cer ata has bean signed by the attendir page 2 should be datached for usa	Completed by Physiclan/M	ATPIN FIRRILLA	Tinal		of death?
<u></u>	n: Th ficata or, pag		25. Was case referred to medical	36 Blees of Dec	th (Check only one)	1 Yes 2 No
5	sicial s certi directo	To Be	examiner? 1 Yes 219 No Hospital: 1 Inpatient 2 FR/0	Out a	ome 5 ☐ Residence 6 ☐ Other (Sp.	ecity)
٥	ar this	اعًا	27. Menner of Deeth 28a. Date of Injury 28b	. Time of lipury at lipury Work?	28d. Describe how injury occurred	00.17)
jo	andin tath. or: Att	ate	2 Accident investigation	M 1 ☐ Yes 2 ☐ No		
Σį	har da	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory, office	28f. Location (Street and Number or F City or Town, State)	Rural Route Number,
	To the Hospital or Attending Physician: The law within 24 hours aftar daath. To the Funeral Director: Aftar this certificata has completaly filled in by the funeral director, page 2	S	29a. Certifier Certifying Physician: To the best of my knowled	an death accurred at the time date and aller-	and due to the gaves(s) and man-	or stated
	24 ho	edical	(Check only one) Addical Examiner: On the basis of exemination of and manner stated.			
	To the Within To the	M	29b. Signature and title of certifier	29c. License number	29d. Date signed (Mon	
			M Galy XHENDI.	59 D 4443	6 MARCH C	18 2004
0	0 11	ŀ	30. Name and address of person who completed cause of deeth (item 23e	(Type, Print)	6 MARCH C	
J	7 9		ASHVINKUMAK J JATOL	. 1021AUL MEllo	N CT WALDORF	mp 20602
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Signature	· double		

DHMH 16 Rev 6/95

DHMH 17 Rev 1/2001

Registrar

MAR 0 9 2004

WALLACE

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			1 = For State Registrar	State of Maryland	Depa	artment of H	ealth and No	Mental Hyg	giene 2004	08991
		4	1. Decedent's Name (First, Middle, Last,					2. Date of Dea Month		3. Time of Death
	Physicia /Medic		Lois Faye Wright	,				March 3	3, 2004 Year	8:15 A M
1	Examin		4a. Fecility Name (If not institution, give	street and number)		4b. City, Town, or			4c. County of Death	_
			187 B Court			Lothian			Anne Arund	
	Funeral Director		413-42-1846	7. Age (In yrs. last 72	Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day August	Year) 9. Birthy Cou. Kent	place (State or Foreign ntry) CUCKY
	and w		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	own or Lo	cation				10d. Inside City Limits
	danyl.	ō	MD A A	la? County Tath						1 ☐ Yes 2 ☐ No
	28a	rect	MD Anne Aruno 10e. Street and Number	del County Loth	ıraıı	10f. Zip Code		1	0g. Citizen of What Cou	ntry?
	ours atter death with the Marylan rai', or Iteme 23e or 28e-f show Examiner must be notified at	Funeral Director	187 B Court			20711			U.S.A.	
	death	ner		12. Was Decedent Ever in U.S. Armed Forces?	13.	Vas Decedent of His Yes, specify Cubar	spanic Origin? (Sp	ecify Yes or No-	14. Race - Ameri Black, White,	
9	or Ite	F	1 ☐ Never Married 2 X Married	1 ☐ Yes 2 X No If Yes, Give		I □ Yes 2 🗓 No		, Tiloan, 5(0.)		ite
5-0036		d by	3 Widowed 4 Divorced	Year or Dates:						
15-	n 72 I	Completed	15. Decedent's Edu (Specify only highest grad	e completed)	6a. Deced (Give life. I	lent's Usual Occupa kind of work done d DO NOT use retired)	ition u <i>ri</i> ng most of worl	ring	16b. Kind of Business/In	dustry
2121	within lene. than "	dwo	Elementary/Secondary (0-12)	Cotlege (1-4or 5+)		emaker			Home	
	filed Hyg the the	Be C	17. Father's Name (First, Middle, Last)		11011		18. Mother's Nam	e (First, Middle,	Maiden Sumame)	
<u>la</u>	buld be Mental arkad o	To B	Robert Richardson				Agnes T	urner		
Maryland	s mand		19a. Informant's Name/Relationship (Ty						, City or Town, State, Zip	Code)
	95 N =		Robert Wayne Wright					-		
Baltimore,	to T		20a. Method of Disposition 1 ☐ Burial 2 🏋 Cremation 3 ☐ F	20b. Place ceme	of Dispo etery, cren	sition (Name of natory or other place			20c. Location - City or To	
Ë	Pag Iment tant: jury o		* 4 ☐ Donation 5 ☐ Other (Specify)	ree (Clinton, Mar	
3al	permit. Pag Department Important: I any injury c		21. Signature of Funeral Services of en	1/2/	22	. Name and Addres	s of Facility Lee	Funeral	L Home Calve	ert, P.A.
	GO E & G		Michael 23a. Part1. Enter the disease, or compl		81	25 Southe	ern Maryl	and Blvo	l., Owings,	MD 20736 Approximate
			shock, or heart failure. List only or Immediate Cause (Final	ne cause on each line.		,		A. C.	951,	Interval Between Onset and Death
3	Physician /Medical		disease or condition resulting in death)	Due to (or as a consequence	rns	mona	1	yperc	nsin	2 years
в	Examiner		1	Ph Doon in	ce or):	21000		Pulm	100 4 5	9
	p Alex	er	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence	ce of):	- orunce		01.0110		
	outed id ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Discare	•					
o,	te be executed ysician and e burial-transit	Ex	resulting in death) Last	Due to (or as a consequent	ce of):					
8760,	a × a	Ilcal		5					1	
x 68	leath certiticat attending phy I for use as the	Mec	IF FEMALE:	72. K.,						
Вох	attend attend for us	ian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea	ath 3□	Ectopic pregnancy			23d. Date of deliver	ery Day Year
o.	that the de led by the a detached i	Physician/Med	1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at time of death 9□Unknown	, 5	Other (specify)			İ	
٥.	The law requires that the death certifica sie has been signed by the attending ph bage 2 should be detached for use as th		Part II. Other significant conditions con	ntributing to death but not resultin	g in the u	ndertying cause give	n in Part I.	23e. Qid tol	bacco use contribute to the	he cause of death?
Records,	puires n sign uld be	d by	Congestive	- heart		Fail	ure_	1,0	s 2□No 3□Prot	oably 4 Unknown
Ö	s been s shoulk	Completed	Insilein &	Sependent	Di	alelis 1	Nellily	24a. Was a		psy findings available
Re	The law ate has page 2 s	E O						autops perform	ned? prior to co death? 2 X No 1 Yes	mpletion of cause of
Vital		Be C	25. Was case referred to medical				26. Place of Deat			22.10
of V	di S	To E	examiner?	fospital: 1 ☐ Inpatient 2 ☐ ER/	Outpatien	t 3 DOA Othe	^C 4 ☐ Nursing Ho	ome 5X Reside	ance 6 □Other (Specif	(y)
			27. Many or of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	b. Time of Injury	28c. Injury Work	?	28d. Describe ho	ow injury occurred	
sio	Attending it death.	catl	2 Accident investigation 3 Suicide 6 Could not be				es 2 □No			
Division	= 00	Certification:	4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, str	et, lactory, office		281. Location (Si City or Town	reet and Number or Rura n, State)	al Route Number,
	pital ours a oral (29a, Certifier L' Certifying Phy	sician: To the best of my knowled	dge death	occurred at the time	e date and place	and due to the o	auso(s) and manner as a	totod
	To the Hospital or At within 24 hours after of To the Funeral Direct completely tilled in by	edicai	(Check only one)	ner: On the basis of examination and manner stated.	and/or in	estigation, in my op	inion, death occur	red at the time, d	ate and place, and due to	the cause(s)
	Nithin Fo the	Me	29b. Signature and title of certifier	1 . M. D.		29c. License	number	2	9d. Date signed (Month,	Pay, Year)
			ATMUM	ending Physi	احت-	D1942	27		3/3/04	
			30. Name and address of person who co						1	
	6		Anwar T. Munshi,			pad, #303	, Prince	Frederic	ck, MD 20678	3
	Sta Registr		31. Date liled (Month, Day, Year) MAR 0	32. Registres Signature 4 2004	K	Spente s				

State of Maryland / Department of Health and Mental Hygiene 2 [] [] [] 08992 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 2004 2:20 p Edgar Russell Wood March /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 8609 Solomons Island Road Owings
If Under 1 Year | If Under 24 Hrs. Calvert 8. Date of Birth (Month, Day, Year) Mar 2, 192 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days 1**∑**M 2□F Months Hours Yrs. 79 213-28-0701 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits or 28a-f show Examiner must be notified at 1 ☐ Yes 2 No Directo MD Calvert Owings 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number or items 23a 8609 Solomons Island Road USA 20736 Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Pages 1 and 2 should be filed within 72 hours after of the following the filed of Health and Mental Hygiene.

ant: if item 27 is marked other then "natural", or ite 1 ☐ Yes 2 No 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced Year or Dates: white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical Elementary/Secondary (0-12) College (1-4or 5+) carpenter, builder construction 11 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 2 Wood Russell Marjorie Harrison 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8609 Solomons Is. Rd., Owings, MD 20736 Lorraine M. Wood, wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Importent: If eny injury or Mt. Harmony Cemetery | 03-09-04 Owings, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility William 100 Owings, Rausch Funeral Home, P.A., MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic month /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner Hospital or Attending Physicien: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) P.0. detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Ceroprovascular autopsy performed? Ilio Dsoas abscess 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Tesidence 6 Other (Specify) ၉ 1 Yes 2 No this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification; Alter 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after deatl To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 50653 - C manana

DHMH 17 Rev 1/2001

State

Registrar

Road.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2004

32. Registra Signature

Olabera.

5851 - Deale Churchton

09

31. Date filed (Month, Day, Year)

GYAN - C.

Drale

SURANA

			1 - For State Registrar	State of I	Maryland	•	artment of rtificate of			-	jiene 20	04 08	993
			1. Decedent's Name (First, Middle	e, Last)						2. Date of Dea Month		3. Time o	of Death
	Physicia /Medic		Carl Wedeking							Februar) a ^M
7	Examin		4a. Facility Name (If not institution	, give street and numb	er)		4b. City, Town,		of Death		4c. County		
			6627 Deep Run				Elkr		O4 Usa			oward	
	Funeral		5. Social Security Number	6. Sex 7. 1 XM 2 ☐ F	Age (In yrs. la 85		If Under 1 Yea Months Days		Min.	8. Date of Birth (Month, Day Nov 19	1918	Birthplece (State (Country) Germany	or Foreign
Ь.	Director		124-09-6521 Usuel Residence of Decedent							1000 19	1910	Germany	
	yland		10a. State 10b. County		10c. City,	, Town or Lo	ocation					10d. Inside C	
	a-fal	ctor	Md How	ard		Elkr.	idge					1 □ Yes	2 N No
	or 28	Director	10e. Street and Number				10f. Zip Code			1	0g. Citizen of W		
	ath w	ra	6627 Deep Run					075				SA - American Indian,	
	er de Items	Funeral	11. Marital Status	12. Was Decede Armed Force 1 XYes 2	s?	5. 13. 2	Was Decedent of If Yes, specify Cu	ban, Mexicai	n, Puerto	Rican, etc.)		k, White, etc.	
36	hours after death with the Maryland tural", or Items 23s or 28s-f show al Examinar mast be notified at	by F	1 ☐ Never Married 2 ☑ Marr 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Date			1 ☐ Yes 2 🔀 No	Specify:	:		Specify:	White	
21215-0036	be filed within 72 hours after death with the Marylan ital Hyglene. ad other than "natural", or items 23a or 28a-1 ahow avant, the Madical Examiner nast be netified at	ted	15. Deceden	t's Education		16a. Dece	dent's Usual Occi	upation	et of worki	na	16b. Kind of Bu		
218	within 7 ene. then "n	Completed	(Specify only highe: Elementary/Secondary (0-12)	College (1-4		life.	DO NOT use retir	ed)				l Security istration	7
21	e filed within al Hygiene. I other than vant, the we	Con	12	4		State	Contrib	-			ACIULII.		
and	be fill stal H bd otf	Be	17. Father's Name (First, Middle,	Last)						•	Maiden Sumami	9)	•
yla	should be nd Menta marked umatic av	ဥ	Karl Wedeking 19a, Informant's Name/Relations	hin (Tyne Print)		19h Mailie	ng Address (Stree		cie B		City or Town	State Zin Code)	
Maryland	d 2 shoth and the and the m. 7 is mutanm		June A. Wedeki				Deep Ru			Elkrid	-	21075	
	ges 1 and 2 should it of Heelth and Men if Item 27 is marks or other traumatic		20a. Method of Disposition		20b. Pla		sition (Name of matory or other pl					City or Town, State	
OL.	Peges nent of I int: if Its iry or o		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		119		Crematio	1	2/9/	2004	Hampstea	ad. MD	
Baltimore,	그 문문을 .		21. Signature of Funeral Service		- CAL	22	2. Name and Add	ress of Facili	ity		22200.50		
Ö	Depa Impo		John K	W.		4	ritts Fu 12 Washi	naton	Road	Westm	inster.	MD 21157	7
	Physician /Medical Examiner		23a. Party. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	only one cause on eac	sed the death. h line. ASTA as a consequence.	JSES				crespiratory arr		Approximal Interval Bel Opeet and	tween
3760,	ate be executed system and he burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	C	as a conseque							tomen	- 110
.O. Box 68	that the death certificat ed by the attending phy detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		t at time of dea	death 3	Ectopic pregnan	су			23d. Date Mon	o of delivery th Day	Year
<u>a</u>	The law requires that te has been signed b page 2 should be deta	þ	Part II. Other significant condition	ons contributing to deat	h but not resul	lting in the u	nderlying cause g	iven in Part I	l,	23a. Did tol		bute to the cause of o	
I Records,		Completed								24a. Was a autops perform	ned2 de	/ere autopsy findings rior to completion of c eath? ☐ Yes 2☐ No	available cause of
Vital	ysician: T	Be	25. Was case referred to medica examiner?	Hospital						(Check only on			
of	Phys this al dii	10	1 ☐ Yes 2 ☐ ☐ Yes 27. Manner of Death	1 □ Inp	atient 2 E	P/Outpatier 28b. Time o					ence 6 Othe		
	ding h. After fune	tion	1 Natural 5 ☐ Pendin	g (Month,	Day Year)	Injury	W	ork? ⊒Yes 2.⊟	P		on injury coconc		
Division	of or Attending after death. I Director: After d in by the fune	ertification:	2 Accident investe 3 Suicide 6 Could 4 Homicide determ	not be 28e. Place of	Injury - At hor , etc. <i>(Specify)</i>	me, farm, str	eet, factory, office	•	2	28f. Location (St City or Town		r or Rural Route Num	nber,
	Hospitel	ledical C	29a. Certifier 1 Certifyir (Check only one)	g Physician: To the be Examiner: On the basi and manner	s of examination	vledge, deatl on and/or in	n occurred at the vestigation, in my	time, date an opinion, dea	nd place, a ath occurre	and due to the ca ed at the time, da	ause(s) and man ate and place, a	ner as stated. nd due to the cause(s	s)
	n 24 hours and Funders and Funderell	60											
	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	Med	29b. Signature and title of certifie	1 0.			29c. Licer	nse number		2	9d. Date signed	(Month, Day, Year)	
•	To the Ho within 24 h To the Fur completely	Med	29b. Signature and title of certifie	Carl	M		29c. Licer	nse number	4	2	9d. Date signed	(Month, Day, Year)	
	To the Ho within 24 h	Med	30. Name and address of person	no completed cause			D2	77	4 a Mr		2-7-0	(Month, Day, Year)	
•	To the Ho within 24 h completely	W	M 4 60	M.D. 2 Ki		orth D	72	77	У а, м		2-7-0	(Month, Day, Year)	

State of Maryland / Department of Health and Mental Hygien 08994 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3 Time of Death 2 Date of Deeth MARCH 2, 2004 **Physician** LOUIS CHARLES WARD 4:45 AM /Medical 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 1505 BREHM ROAD WESTMINSTER CARROLL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State of Country)

APRIL 25, 1932 MARYLAND Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. lest birthday) **Funeral** Months Days Hours 1 □ M 2 □ F Yrs. 216-28-1013 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Meryland Deportment of Health and Mental Hygiene. Important: If term 27 is marked other than "naturel", or items 23a or 28a-f show any Injury or other traumatic event. It a Medical Exercise. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes XX No Director MARYLAND CARROLL WESTMINSTER 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 1505 BREHM ROAD 21157 UNITED STATES Funeral 12. Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Detes: 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify: Completed by WHITE 3 Widowed 4 Divorced 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) FIRE DEPARTMENT FIREFIGHTER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) GEORGIA FLAINE FORD CLARENCE OSCAR WARD 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) DONNA J. SCHWARTZ/DAUGHTER 1505 BREHM ROAD, WESTMINSTER, MD 20b. Place of Disposition (Name of cemetery, crematory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 3/5/04 HAMPSTEAD, MARYLAND CARROLL CREMATION 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
MYERS-DURBORAW FUNERAL HOME, P.A. 91 WILLIS ST, WESTMINSTER, MD 21157 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Myelodysplasia
Due to (of as a consequence of): **Examiner** Physician/Medical Examiner is certificate has been signed by the ettending physician end director, page 2 should be deteched for use as the burial-trensif The law requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Due to (or as e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown KHOWH Nohe þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy Completed 1 ☐ Yes 2 No 1 □ Yes 2 □ No or Attending Physician: Be 25. Was cese referred to medical 26. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No this 28c. Injury et Work? 28a. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 27. Manper of Deeth 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. versi Director: A filled in by the fu 2 Accident investigetion 6 ☐ Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral C completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Certifier (Check only one) 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Yeer) MJ # D15552 , M.D. 3/2/04

MJr

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print)

HOWARD SAIONTZ M.D. 555 S. CENTER STE

. 555 S. CENTER STREET, WESTMINSTER, MD 21157

State 31. Date filed (Month, Day, Year)
Registrar MAR

0 5 2004 Market Signature

OPIGINAL OPIGINAL

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2004 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 7:15 AM tebruary 2000 Philip Craig Zeger

4e Fecility Neme (If not institution, give street end number) /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner 140 Hump Road Washington County 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year 5. Social Security Number 6 Sex 7. Age (In yrs. lest birthday) **Funeral** Days Hours Min. Months **½** M 2□ F 52 Yrs. May 30 1951 Maryland Director 216-54-8150 Usuel Residence of Decedent permit. Peges 1 end 2 should be filed within 72 hours effer death with the Maryland Depertment of Health end Mental Hygiene. Important: If Itam 27 is marked other than "natural" any injury or other traumatic excessions. 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1 ☐ Yes 2 1 No Director Hagerstown Washington Maryland 10g. Citizen of What Country? 10e. Street end Numbe 10f. Zip Code 21740 U.S.A. 140 Hump Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: Race - American Indian, Black, White, etc. 11. Merital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify.White δ 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) City Government 12 Equipment Operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Helen Louise Barron Roy Milton Zeger 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Norma J. Zeger/Wife 140 Hump Road Hagerstown, Maryland 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition XBurial 2 Cremation 3 Removal from State Grenlawn Mem. Park Mar. 3,04 Williamsport, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. N. Hagerstown, Maryland 21742 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician Immediate Cause (Final disease or condition resulting in death) /Medical Estroine Due to (or as a consequence of): Physician/Medical Examiner Due to (or es e consequence of) Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events Due to (or as e consequence of): resulting in death) Last 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 3 Probably 4 □ Unknown 1 ☐ Yes 2 ☐ No Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 21 No 4 Ves 1 ☐ Yes 2 ☐ No director. 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA 28c. Injury at Work? 27. Menn Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 5 Pending investigation 1 Natural

or Attending Physician: The law requires that the death certificate be executed nding physicien end use es the buriel-trensit Division of Vital Records, P.O. Box 68760, attending (sete hes been signed by the a pege 2 should be deteched certificete hes Certification: To this I Director: Af and in by the fu

2 Accident

3 Suicide

4 Homicide

6 Could not be

Hospi 24 hou Funer Indiana Signature Signature Signature	29a. Certifier (Check only one) 1	eath occurred at the time, date and place, and due to the investigation, in my opinion, death occurred et the time.	he cause(s) and manner as stated. ne, date and place, and due to the cause(s)
within To the comp	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
F 3 F 8	tudue 11 1	N23623	march 2 way
15/15	30. Name and address of person who completed cause of death (Item 23a) (Type	pe, Print)	~
D1.51	Frederic H KASIE AND III	is hed cel Can	rus Rel Hegerstown
State Registrar	31. Dete filed (Month, Day, Year) MAR 10 2004 32. Begistrar's Signature	parke	ma

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

Pe 2 2

			State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2004 089	396
	Physici	an	1. Decedent's Name (First, Middle, Last) RICHARD EUGENE ALSTON 2. Date of Death 0 Month 19 Day 2004 Year 2:15 P	ath
The same	/Medic	cal	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death	
	Examir	ier	IOI MAIN STREET TURNERS STATION BALTIMORE	
Ē	Funeral Director		5. Social Security Number 226-60-5717 1 N M 2 F 57 Yrs. The security Number 25 1 N M 2 F 57 Yrs. The security Number 25 1 N Months Days Hours Min. 1 N Min.	oreign
	land w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Lim	imits
	Mary a-f eh	tor	MD BALTIMORE TURNERS STATION TO THE TRANSPORT OF THE PROPERTY	□No
	th with the 23a or 28	ai Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 101 MAIN STREET 21222 USA	
036	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artiment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural; or items 23a or 28a-f show injury or other traumatic event, the Medical Examinar fruit be multipled at injury or other traumatic event, the Medical Examinar fruit be multipled at a.	by Funerai	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 15. Yes 2 No Specify: BLACK	
21215-0036	within 72 ho iene. Ihan natu	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) GUARD 16a. Decedent's Usual Occupation (Give kind of work done during most of working (file DO NOT use retired) HOWARD CO. DET. CENT.	TER
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Maryland	12 sho h and 7 is mu iraum		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) OHADJENE DICKED COM/DED. EDITEMD. 101 MAIN CEDETE. DATE TIMODE. MD. 21222	
Baltimore, I	ges 1 and t of Healtl if item 27 or other 1		CHARLENE DICKERSON/DEP. FRIEND 101 MAIN STREET, BALTIMORE, MD 21222 20a. Method of Disposition 1 □ Burial 2 Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State	
tim	permit. Page Department o Important: If eny injury or once.		'4 Donation 5 Other (Specify) METRO CREMATORY 3/22/04 BALTIMORE, MD	TATO
Ba	Deparenti Importenti eny ir		1701 LAURENS ST., BALTO., MD 21217	
	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. CONCESTIVE HEART FAILURE Due to (or as a consequence of):	en ith
,092	te be executed was any sician and be burial-transit	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last b. CRONRY AFTEKY Due to (or as a consequence of): C. Due to (or as a consequence of): d.	
P.O. Box 68	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 23d. Date of delivery 23d. Date of delivery Month Day Year	r
	w requires that the been signed by th should be detache	ted by Ph	Part fl, Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? CHRONIC OBSTRUCTIVE PULMONARY DIJERE 1 Yes 2 No 3 Probably 4 Unknown	
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Vital	ysician: is certifica director, (Bec	25. Was case reterred to medical axaminer?	
of	Phy this ald	n; To	1 Yes 2 No Hospitaf: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work? 28d. Date of Injury at Work?	
Division	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification;	1 Statural 5 Pending investigation 2 Accident 3 Suicide 4 Homicide 1 Plane determined 2 Accident 5 Statural 5 Pending investigation 1 Plane 1 Plane 1 Plane 1 Plane 1 Plane 2 Place of Injury - At home, farm, street, factory, office 289. Place of Injury - At home, farm, street, factory, office 296. Location (Street and Number or Rural Route Number, City or Town, State)	,
, -	Hospital 24 hours Funeral tely filled	Medica Ce	29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of camination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
	within 2 To the comple	Med	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	/
	N		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	1
	Sta	ite	31. Date filed (Month, Day, Year) MAR 2 2 2004 MAR 2 2 2004 MAR 2 2 2004	- 10
1	Registi		MAR 2 2 2004 See See See See See See See See See Se	

			For Stata Registrar	State of Maryla	•	artment of rtificate of		•	giene Reg. No. 20 (08997
	Physici /Medio		1. Decedent's Name (First, Middle, La.	4 molls				2. Date of Dea	Day Ye	1 10 cm
	Examir Funeral	er	4a. Facility Name (If not institution, given Hamilton Nursi 5. Social Security Number 6. S	ng Home	rs. last birthday)	4b. City, Town, Baltim If Under 1 Year	ore if Under 2	4 Hrs. 8. Date of Birt	4c. County of D	
	Director		Usual Residence of Decedent	□ M 2 💢 F 91	Yrs.	Months Days	Hours	Min. (Month, Da 10 02	12	Birthplace (State or Foreign Country) NC
	he Marylar 18a-1 show	Director	MD NA		city, Town or Lo				10g. Citizen of What	10d. Inside City Limits VIXYes 2 □ No
036	within 72 hours after death with the Maryland ene. than 'natural', or items 23e or 28e-1 show ts Medical Evertii er rast be rudiffed at	by Funeral	10e. Street and Number 1635 Poplar Gr 11. Marital Status 1 Never Married 2 Married **Widowed 4 Divorced	ove Street 12. Was Decedent Ever in Armed Forces? 1		212	Hispanic Orig pan, Mexican,	in? (Specify Yes or No- Puerto Rican, etc.)	U.S.A	•
21215-0036	ad within 72 ho rgiene. er than "natur it, the Medical.	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12) 7th grade	College (1-4or 5+)	(Give	dent's Usual Occu kind of work done DO NOT use retin use Kee	per		16b. Kind of Busine	
Maryland	should be file nd Mental Hy marked oth umatic event	Be	17. Father's Name (First, Middle, Last) Clayton Streete 19a. Informant's Name/Relationship (r	19b. Mailir	ng Address (Stree	Clar	's Name (First, Middle, a Dupree or Rural Route Numbe		e, Zip Code)
Baltimore, Ma	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examined resist by rollified at Once.		Nevie White-Ni 20a. Method of Disposition **MBurial 2 Cremation 3 Content (Specific Signature of Funeral Service Cont	Removal from State	D. Place of Disponder Commetery, cremosory,	sition (Name of matory or other pla n Cemet 2. Name and Addr arch F/	ery 3	t	20c. Location - City	or Town, State
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.O. Box 68	death certific e attending p ed for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of	etal death 3	Ectopic pregnand Other (specify)	ру ————————————————————————————————————		23d. Date of Month	delivery Day Year
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of Vital Record	The lar ate has page 2	Completed						24a. Was autop perfor 1 ☐ Yes	sy prior	
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Division	To the Hospital or Attending I within 24 hours after death. To the Funeral Director; After completely filled in by the funer	Certification:	2 Accident investigation 3 Suicide 6 Could not b 4 Homicide determined		t home, farm, str ecify)			-		Rural Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	edical C		ysician: To the best of my ininer: On the basis of exam and manner stated.						
	/	Ž	29b. Signature and title of certifier	- Zras1	Motor	m 29c. Licen	Se number		29d. Date signed (Mo	-0
_	<u>ප</u>		30. Name and address of person who	150 700	1 rock	Primare	N 18h	A, Rallin	1016 M	751586
	Sta Registi		31. Date filed (Month, Day, Year) MAR 2 2 200	32: Registrar's Si	gnature	D				

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ŀΡ			1 - For State Registrar	State of Ma	ryland / Depa <i>Ce</i>	artment of <i>rtificate o</i>			lental Hy	giene Reg. No. 2 (104	08998
	Physicia /Medic		Decedent's Name (First, Middle, Last) Lee Milton	Beauchar	тр			18.4	2. Date of De Month	Day 2004	Year	3. Time of Death 1:14 a M
	Examin	er	4a. Fecility Name (If not institution, give s 3028 REMMINGTON AV	ENUE		4b. City, Town	ORE C	ITY		4c. County		
	Funeral Director		210 10 7207	M 2□F	(In yrs. last birthday) 82 Yrs.	Months Day		er 24 Hrs. Min.	8. Date of Bin (Month, Da April 24	, 1921	9. Birthe Cour Mary	otece (State or Foreign and
	Maryland f show	lor	Usual Residence of Decedent 10a. State 10b. County MD n/a		10c. City, Town or Lo Baltim						1	0d. Inside City Limits 1 No 2 No
	h with the 23e or 28e at be notif	al Direc	10e. Street and Number 3028 Remington Avenue	·. · · · · · · · · · · · · · · · · · ·	10f. Zip Code 2121		~		10g. Citizen of USA	g. Citizen of What Country? USA		
36	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f show the Modical Examinist must be notified at	by Funeral Director	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates:	W II	Was Decedent of if Yes, specify Control of the Yes 2000 N	uban, Mexic	an, Puerto	ecify Yes or No Rican, etc.)	Bla	ce-Americ ck, White, y: Whit	etc.
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinar must be notified at once.	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give	re kind of work doné during most of working DO NOT use retired) CE Officer Ba				Baltimore	6b. Kind of Business/Industry altimore City Government	
/land	ould be file Mental Hy, arked other	To Be C	17. Father's Name (First, Middle, Last) Frederick B.	Beauchamp				her's Name	Anna	Gebert	ne)	
, Man	and 2 sho saith and i n 27 is me		19a. Informant's Name/Relationship (Ty) Linda M. Schwirian-nie		700 Ma	ng Address (Stre Ayton Cour		Air, M	Maryland_	21014		
Baltimore,	Pages 1 ment of Hi ant: If iter ury or oth		20a. Method of Disposition 1 🕱 Burial 2 ☐ Cremation 3 ☐ R 1 ☐ Donation 5 ☐ Other (Specify)		20b. Place of Dispo cometery, cre- Parkwood Co	matory or other penetery		3/25/0		Baltimor	e, MD	
Balt	permit. Departimport any inj		21. Signature of Funeral Service License		į	2. Name and Add 5305 Harfo	ord Rd.	, Balti	more, MD	21214	Funer	
	Physician /Medical Examiner	5	23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	Due to (or as a	consequence of):					rest,		Approximate Interval Between Onset and Death
8X60,	icate be executed physician and s the burial-transit	dical Examiner	in any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	Due to (or as a								
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rds, P	es be	by	1 - Von 2 - Vo									ne cause of death? ably 4 Unknown
Division of Vital Record	The law ate has b page 2 sl	Completed							12 Yes	med? 2 No	Were auto prior to cor death? 1 Xes	psy findings available inpletion of cause of
Z.	Physician: Th this certificate ral director, pag	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital:	ER/Outpatier	nt 3 DOA	1ther		n <i>Check on vo</i> me 5 XX esio	ne/ lence 6 □Oth	er (Specif	v)
ion o	ding After fune	atlon: T	27. Manner of Death 1 □ Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Found March 20, 200		V	ijury at vork? Yes 2			ow injury occur Shot sei		
Divis	Dire	Certification	3 Suicide 6 Could not be 4 Homicide determined		y - At home, farm, str (Specify)	reet, factory, offic	ce .		City or Tox	itreet and Numb n, State)		l Route Number,
	Hospitai 24 hours a Funerai i	edical	29a. Certifier 1 Certifying Phys	sician: To the best of ter: On the basis of a and manner state	administion discourse	h occurred at the	time, date y opimon, o	and place, a	and due to the	cause(s) and ma date and place,	inner as st	ated. the cause(S)
,	To the l	Med	A	renhere	NO	OCM	ense numbe	r	1	29d. Date signe ARCH 20	•	* * * * * * * * * * * * * * * * * * * *
	Sta	te	30. Name and address of person who co TCLShct. Z. GIVEEN 31. Date filed (Month, Day, Year)).	111 F	enn S	treet	, Balti	more, M	aryla	and 21201

			For State Registrar	State of Maryland /	Department of Hea		ntal Hygie Reg.	21111L	08999
	Physici /Medic		1. Decedent's Name (First, Middle, Last)	Christine	Bartholo	100 01/	Date of Death Month WEB 2	Day Year	3. Time of Death
	Examin		4a. Facility Name (If not institution, give s SI- CI Z M + H 5. Social Security Number 6. Sex	NUVSING Cel	Months Days	tunder 24 Hrs. 8	Date of Birth (Month, Day, Ye	None 9. Birth	oplace (State or Foreign
€,	Director		216 10 3633 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	M 2XF 89	Yrs. World's Days				10d. Inside City Limits
	he Maryla 28a-f shor	Director	MD None		timore		100	Citizen of What Co	1 ∑XYes 2 ☐ No
	with	늄			21227		.09.	United St	•
	e 23	ra	3320 Benson Avenue	2. Was Decedent Ever in U.S.		anio Origin2 (Specify	Ves or No-	14. Race - Amer	
920	hours after deeth with the Maryland tural', or Itame 23a or 28a-f ahow al Exerciper must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	Armed Forces? 1 Tyes 232 No If Yes, Give Year or Dates:	13. Was Decedent of Hispa If Yes, specify Cuban, I	Mexican, Puerto Rici	an, etc.)	Black, White	
Maryland 21215-0036	in 72 n "nai	Completed	15. Decedent's Educ (Specify only highest grade		ia. Decedent's Usual Occupatio (Give kind of work done duri life. DO NOT use retired)		166	. Kind of Business/l	ndustry
nd 21	Hyg F th	Be Con	17. Father's Name (First, Middle, Last)	2		B. Mother's Name (F	irst, Middle, Maid		of the Navy
aryla	s 1 and 2 should be Heelth and Mental Item 27 Is marked o other traumatic eve	ဥ	Vincent Musacchio 19a. Informant's Name/Relationship (Type	pe, Print) 19	9b. Mailing Address (Street and	ary D'Anto		ity or Town, State, Z	ip Code)
	1 and 2 Heelth Iem 27 other tra	14	Regina Zielinski/Da		2616 Thornbroo				
Baltimore,	Pages 1 all nent of Hee int: If Item iry or othe		20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☐ Re 1 ☐ Donation 5 ☐ Other (Specify)	emoval from State	of Disposition (Name of tery, crematory or other place) t Lawn Mem. Ga:	rd. 3-24-		Location - City or 1	
Balti	permit. Pages Department of I Important: If Its any Injury or o		21. Signature of Funeral Service License	M01044	22. Name and Address of 4112 Old Co.		44		
	Physician /Medical		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on etach line.	nontia	such as cardiac or re	spiratory arrest,		Approximate Interval Between Onset and Death
8760,	Examiner	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	oon:				wealcs
O. Box 6	The law requires that the death certificate be executed to has been signed by the attending physicien and bage 2 should be detached for use as the buriat-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	Sc. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 4 Pregnant at time of death 9 Unknown	th 3 Ectopic pregnancy 5 Other (specify)			23d. Date of delin	very Day Year
Q.	uires that signed by Id be deta	by	Part II. Other significant conditions con	tributing to death but not resulting	in the underlying cause given i	in Part I.	23e. Did tobacc	co use contribute to 2 □ No 3 □ Pro	
Vital Records,		Completed					24a. Was an autopsy performed 1 Yes 2	prior to c death?	opsy findings available ompletion of cause of
/its	ician: Th certificate ector, pag	Be	25. Was case referred to medical examiner?	anital		6. Place of Death (C	heck only one)		
of	Physician: this certific ral director,	2	1 105 2 110		Outpatient 3 DOA Other:	4 Nursing Home			ify)
ū		.uo	27. Manner of Death 1. ☑ Natural 5 ☐ Pending	28a. Date of Injury 28b (Month, Day Year)	. Time of linjury at Work?		. Describe how in	njury occurred	
Division	eat or:	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)		s 2 No 28f.	Location (Street City or Town, St	and Number or Rui ate)	ral Route Number,
_	To the Hospital or Att within 24 hours after of To the Funerel Direct completely filled in by	edical Co	29a. Certifier (Check only one) 1 Certifying Phys 2 Medical Exemin	ician: To the best of my knowled er: On the basis of examination a and manner stated.	ge, death occurred at the time, and/or investigation, in my opini	date and place, and ion, death occurred a	due to the cause at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
_	o the	¥ €	29b. Signature and title of certifier	/ 1	29c. License ni	umber	29d.	Date signed (Month	Day, Year)
•	W STO		30. Name and address of person who cou	moleta/cause of death (from 33-	D 3	539	Mo	aryland	, 2004
			30. Name and address of person who cold the state of the	32. Registrar's Signature	renue, 13	altimo	re Mi	aryland	75515
1	Sta Registr		MAD o o 2		Audi.				

ORIGINAL

			1- State of Marylan	d / Department of Hea Certificate of De	alth and Mental F Eath	Hygiene 200	09000
		4	Decedent's Name (First, Middle, Last)	- · - · · ·	2. Date of Month	Death , Day, Year	3. Time of Death
8	Physici /Medic		Odessa Caldas		Marie		+ 2205 M
	Examin		4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Loc		4c. County of Dea	ath A
	55 - 6 ay	-	Johns Hopkins Bayvilw Mel 5. Social Security Number 6. Sex 7. Age (In yrs.		Under 24 Hrs. 8. Date of	Righ 9 Bi	rthplace (State or Foreign
18. 18.5	Funeral Director		213-28-0817 1 M 2 x F 83		lours Min. (Month,	Day, Year) 0-1920	Texas
	D		Usuel Residence of Decedent			1,20	
	srylan	ڀ	MD BALTO.	y, Town or Location INERS STATION			10d. Inside City Limits 17€ Yes 2 □ No
	Ne Mi	Director	10e. Street and Number	10f. Zip Code		10g. Citizen of What C	
	with the or the or			21222		USA	ourney.
	ms 23	Funerai	410 CHESTNUT COURT 11. Marital Status 12. Was Decedent Ever in U.		nic Origin? (Specify Yes or		
စ	within 72 hours after death with the Maryland ene. than "natural", or tlems 23e or 28e-f show the Maryleal Existing the maillist at	Fur	Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ♥ No If Yes, Give	4-4	exican, Puerto Hican, etc.) pecify:	Black, Whi	
003	ural',	d by	3 Widowed 4 Divorced Year or Dates:				
5-	"nati	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done durin life. DO NOT use retired)	n g most of working	16b. Kind of Business	Vindustry
12	filed withii Hygiene. other than	omp	Elementary/Secondary (0-12) College (1-4or 5+)	BEAUTICIAN		BEAUTY SAI	ON
פ	e filed Il Hygi other	Be C	17. Father's Name (First, Middle, Last)		Mother's Name (First, Mid		
/lar	2 should be filed within and Mental Hygiene. is marked other than aumatic avent, the M.	ToE	GEORGE O' BRYANT		HATTIE ()'BRYANT	
Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Marylan It of Health and Mental Hyglene. If Item 27 is marked other than "natural", or Items 23e or 28e-f show or other traumatic event, the Madical Extending the natified at		19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and		-	
	1 and 1ealth em 27 ther tr		BEVERLY SMITH/FRIEND 20a. Method of Disposition 20b. P	1319 MAPLE AV	Date	20c. Location - City of	
Baltimore,	Pages nent of h int: If ite		1 Surial 2 □ Cremation 3 □ Removal from State	emetery, crematory or other place)	3/25/04		
Ħ	permit. Pages 1 and 2: Department of Health at Important: If tiem 27 is any injury or other trau		21. Signature of Funeral Service Licensee	WNSVILLE 22. Name and Address of	Facility JAMES A.	CROWNSVILLI MORTON & SO	
ä	permit. Departn Imports any inju		James a. Morton		ENS STREET, I		
	LEGG M F		23a. Part1. Enter the disease, or complications that caused the deati shock, or heart failure. List only one cause on each line.	h. Do not enter the mode of dying, so	uch as cardiac or respirator	y arrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition PNEUMO	coccal Pheumo	onia		Onset and Death
	/Medical Examiner	į.	resulting in death) Due to (or as a conseq	uence of):			
0.	LAGITIMICI	7	Sequentially list conditions, if any leading to immediate Due to (or as a conseq	uence of):			
	ted nsit	nine	cause. Enter Underlying Cause (Disease or injury	301100 01).			
Ć,	execunand and ial-tra	Examiner	that initiated events c	uence of):			
8760,	cate be executed physician and the burial-transit	dical	d				
9	ntifica ng ph	Med	IF FEMALE:	TARE			
Вох	that the death certifice ed by the attending pl detached for use as t	Physician/Med	23b. Was decedent pregnant 1 Live birth 2 Feta	I death 3 Ectopic pregnancy		23d. Date of de Month	livery Day Year
o.	the a	ysic	1 ☐ Yes 2 No 9 ☐ Unknown 9 ☐ Unknown	eath 5 Other (specify)		-	
P. 0.	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	/ Ph	Part II. Other significant conditions contributing to death but not resi	ulting in the underlying cause given in	Part I. 23e. D	id tobacco use contribute t	o the cause of death?
ds	luires tha	d by	Acute Renal Failure,	typoalbuminer	nia 1	□Yes 2 No 3□P	robably 4 Unknown
Ö	s been s should	oiete		į r	24a. W	as an 24b. Were a	utopsy findings available
æ	The lay	Completed				nformed? death?	completion of cause of
Division of Vital Records,		BeC	25. Was case referred to medical examiner?	26.	Place of Death (Check on		
<u>≻</u>	Physic this ce al dire	ဥ	1 Yes 2 No Hospital: Inpatient 2		Nursing Home 5 R		ocify)
ü	ing P	ion:	27. Manner of Death Natural 5 Pending (Month, Day Year)	28b. Time of Injury at Work? M 28c. Injury at Work? 1 ☐ Yes		e how injury occurred	
isi	l or Attending I after death. Director: After I in by the funer	ficat	2 Accident investigation 3 Suicide 6 Could not be determined	ome, farm, street, factory, office		n (Street and Number or R	ural Route Number,
<u>S</u>	al or A after 1 Direct d in by	Certification:	4 Homicide determined building, etc. (Specify	y)	City or	Town, State)	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,		29a. Certifier Certifying Physicien: To the best of my kno (Check only 2 Medicel Exeminer: On the basis of examina	wiedge, death occurred at the time, d	ate and place, and due to t	he cause(s) and manner a	s stated.
	the Hi	Medical	one) and manner stated.				
)	To To	2	29b. Signature and title of certifier	29c. License nur	mber	29d. Date signed (Mon	ICI 2004
•	1		TIENONO 1000	230	110	March 20 Conter 6	11200,
	N		30. Name and address of person who completed cause of death (Item	and the same of th	200 Medica	20 Couter 6	Baltimore MIN
i e	Sta	ite	31. Date filed (Month, Day, Year) 32. Degistrar's Signa		7-0000	- Colores	
	Registr	ar	MAR 2 2 2004	& And			